Muskuloskeletalt Forum

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Dansk Selskab for Muskuloskeletal Medicin &
Danske Fysioterapeuters Fagforum for Muskuloskeletal Terapi

Indhold

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Forum

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Leder

Allan Gravesen

Synlighed

Synlighed er et mantra for alle virksomheder, der har et produkt de gerne vil sælge, vise eller på anden måde bringe frem.

I DSMM vil vi gerne være synlige over for vores målgruppe. Det er alle læger med interesse for muskuloskeletal medicin eller med mulig interesse for muskuloskeletal medicin.

Yngre læger under uddannelse har selvfølgelig en fornemmelse af hvad deres uddannelse skal indeholde, men det er ikke altid at man lige ved man står og mangler et kursus i rygundersøgelse og –behandling. Mange praktiserende læger vil i deres kliniske hverdag have glæde af at komme på kursus i muskuloskeletal medicin, ikke mindst hvis der i overenskomsten bliver indført specialtakst for manuel behandling af patienterne.

Mange speciallæger inden for reumatologi og ortopædkirurgi vil også i deres kliniske virke kunne bruge vore kurser.

En anden målgruppe er de fysioterapeuter, der er under uddannelse i manuel terapi, og som søger den måde vi tilrettelægger vores kurser.

Derfor vil vi i DSMM gerne prøve at blive mere synlige. Vores kurser er vores produkt og vores kursustilbud skal vi sørge for kommer bredt ud.

Uddannelsesudvalget og lærergruppen skal primo maj diskutere nye kurser og ny tilrettelæggelse af de eksisterende kursustilbud.

Vi vil i løbet af i år forsøge at lancere en annoncekampagne i forskellige medier. En annoncekampagne, hvor du som medlem af DSMM meget gerne må bakke op om vores produkt og fortælle dine kolleger om dine erfaringer med at være på muskuloskeletal kursus.

Måske mangler du selv en opdatering eller har lyst til at lære om nye behandlingsmuligheder?

Vi glæder os til at beskrive og fortælle om vores nye kursusstruktur i det næste nummer af Muskuloskeletalt Forum.

HUSK, at du kan få de små patientpjecer hos Birthe Skov

Patientpjecerne kan du bruge i din klinik til udlevering. I pjecen beskrives muskuloskeletal medicin og behandling på et letlæst og forståeligt sprog.

Kontakt *Birthe Skov*

DSMM's hjemmside:

DSMM har oprettet et lukket område på vores hjemmeside.

Det skal bruges til f.eks. regnskaber o.lign. Du finder det ved at skrive www.dsmm.org/lukket

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HUSK at password er til medlemmernes brug og det skal ikke videregives til andre.

Allan Gravesen

Leder

Niels Honoré

Fagforum og Specialistordning

Hovedbestyrelsen har godkendt vores ansøgning og nu hedder vi altså Danske Fysioterapeuters fagforum for Muskuloskeletal Terapi! Endvidere har hovedbestyrelsen nu endeligt vedtaget specialistordningen. De to første områder der kan søge om godkendelse er speciale i neurofysioterapi og speciale i muskuloskeletal fysioterapi. Kravene til fremtidens specialister er følgende:

Grundlæggende krav til specialistgodkendelse

- Grunduddannelse til fysioterapeut 180/210 ECTS
- Dansk autorisation som fysioterapeut
- Medlem af Danske Fysioterapeuter
- Generel arbejdserfaring svarende til 2 års fuldtidsarbejde

Klinisk uddannelsesforløb

- 3 års klinisk arbejde indenfor specialistområdet med dokumenteret klinisk vejledning Arbejdstiden må mindst være gennemsnitlig 18 timer pr. uge
- De 3 år kan løbe parallelt med specialistuddannelsesforløbet
- Kompetenceudvikling indenfor supervision, minimum 150 timer
- Undervisning og formidling opgivet i ECTS
- Dokumenteret efteruddannelse med relevans til området opgivet i ECTS

Teoretisk uddannelsesforløb

- Master eller kandidateksamen med projekt i relation til specialistområdet
- Foredrag med emne i specialistområdet, konferencedeltagelse med indsendt abstract, eller accepteret artikel i forskningstidsskrift
- Dokumenteret deltagelse i kurser, workshops, konferencer på specialistområdet opgivet i ECTS
- Dokumenteret efter- og videreuddannelse opgivet i ECTS

Endvidere skal specialisterne bl.a. kunne følgende:

- Specialistens faglige kompetence er kroppens biomekaniske forhold: led, knogler, sener, muskler, nervesystem, og bindevævs funktioner og indbyrdes påvirkninger.
- Specialisten kan identificere komplekse og komplicerede dysfunktioner i bevægeapparatet og kan behandle disse udfra et velargumenteret løsningsforslag på baggrund af klinisk ræssonering.

Det bliver spændende at se hvor mange specialister vi får, og mon ikke en af de første specialister i Danmark bliver en fra Danske Fysioterapeuters fagforum for Muskuloskeletal Terapi.

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Send pr. e-mail til redaktøren (ansvarshavende).
Eller indsend på diskette.

Perspectives on the biopsychosocial model – part 2: the shopping basket approach

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Introduction – "in series" versus "in parallel" management

When I first trained, in the early 1980's, and later, when I did my manual therapy training, a major emphasis of assessment was to find the structural or tissue source of the patient's problem and to then perform one technique at a time to the presumed source. While giving the technique it was important to assess progress by focusing on the pain response to the technique (what's happening to your pain, where is your pain, how does this feel, what's happening now, etc etc ...) and then re-examining the pain response and quality of a physical movement (where's the pain now, what's happening to the pain; better, same or worse? etc.). Taking a term from basic electricity wiring diagrams, this process can be seen as an "in series" one, whereby one procedure at a time had to be proved and performing several techniques at once i.e. "in-parallel", would muddy the proving process. In much of my training and early work as a manual therapist even giving an exercise before a technique had been proven was frowned upon – if you do many things at once, one thing might be helping, while another may be detrimental – was the logic that was applied. It fitted the approach and seemed a logical way to work.

In the light of currently available research this purist "in series" style of approach appears incomplete, inefficient and needs to be criticised:

- It is very passive. It takes control away from the patient and leaves them with little responsibility. It promotes passivity by the patient and the expectation that the clinician will fix the problem.
- It is over-reliant and over-focused on pain response and pain relief. It assumes that instantaneous improvements in pain and pain response to movement are a reliable indicator of recovery (see discussion on pain and pain treatments, part I (Gifford 2001). Restoration of good quality and less painful movements is not being criticised, so long as the new movements gained can in some way be generalised into the patients active life.
- It focuses on pain, sometimes almost continuously. Therapists trained in this way almost constantly and automatically use "pain talk" when assessing and managing the patient (a very difficult habit to break – I think its taken me 10 years at least). As argued elsewhere (Gifford 1998), if you focus too often and too much on pain, you may in effect help to memorise it thereby increasing its potential long-term impact on the circuitry of the central nervous system – hence chronic pain.
- It is over-focused on a single physical source (see part I (Gifford 2001)).
- It assumes that we are capable of finding a single "source" of a problem and it focuses too much attention on individual structures and tissues as being "pathological", damaged; dysfunctional, imbalanced, weak, vulnerable ...
  It over-focuses on single or multiple physical impairments found by the clinician. In reality any "in series" approach like this one is very much linked to the biomedical model of health and disease. Unfortunately, the available evidence suggests that a purely biomedical approach – such as one where physical impairments are a main source of attention, is only very weakly linked to levels of pain and the development of pain disability.

A freer "In parallel" analysis and management approach allows clinical reasoning to consider multiple factors that may play a role in the following two important issues for patients reporting musculoskeletal pain:

1. The generation and maintenance of the patients pain.
2. The generation and maintenance of the patients physical incapacity or disability.

When I learnt them, the approaches outlined above did not separate the two issues. There was little focus on function or disability and an assumption that they would right themselves once the pain went. If the pain did not go or diminish with treatment – the patient either drifted off or was referred back to the Dr. I had nothing left to offer.

If it helps the following are three significant "steps forward" that happened to me.

- The first major step occurred when I realised that a patient's *disability or incapacity* related to their *performance* – in other words their willingness or confidence to do a movement. For example, I used to examine forward flexion by asking about resting pain then asking the patient to bend forward and report what happened to the pain. Now I might approach forward bending by asking the patient if they are willing to bend forward and if so to show me what they can do or feel confident to do. I am interested in their willingness to move and in their fear of the movement. I also look at the same movement performed from different starting positions in order to find out if the patient is capable of the movement in a more confident way. Performance, and hence range and quality of movement relates to psychological factors, in particular to fear and anxiety.
- The second occurred when I started to see pain and disability as separate issues, but to investigate and manage them *together* and in a much more balanced way. The joy of this approach is that with the majority of sub-acute, pre-chronic and longer term chronic-pain patients there is an ever increasing shift away from an inefficient and frustrating focus on pain reasoning, assessment and relief, towards improved function, improved physical confidence and pain *management*. This was a style of approach that was at once far more rewarding, a lot more predictable and far less pressurised. Life is nothing without physical confidence and physical function – you simply cannot live if you cannot do. Also, the common spin-off to improved performance/ physical confidence is a reduction in symptoms, a better acceptance of symptoms and a much improved ability to cope.
- The third, was when I came to feel comfortable with the notion that "pain treatments" are not very effective and frustratingly unpredictable – and that the longer a problem has been around the less effective any form of pain treatment tended to become. When treatments are successful I now reason that their mode of action is most likely to be via altered "information processing" rather than any significant change in the tissues where the treatments are applied. This allows me to feel comfortable as well as confident with the placebo phenomenon and thus with any form of pain relief approach. If it's helpful – use it!

The biopsychosocial model of health and disease (see Waddell 1998, Roberts 2000) is multidimensional (in parallel) in that it seeks to explore all the factors that may be involved in the pain and the disability related to the patient and their presentation.

The factors are:

1. The social and work environment.
2. The type of behaviour adopted by the patient (illness behaviour).
3. The levels of distress.
4. The patients attitudes and beliefs.
5. The pain.

The approach advocated is for physiotherapists to embrace the biopsychosocial model of health and disease and as a result embrace a far broader and multidimensional perspective on all conditions that we see. This ultimately involves dealing with more than one thing at a time, often holding back on "hands on" or passive/active correction of minor impairments and thinking and managing in a very much more "in parallel" style.

For me, the result of the last 10 or so years of integration of pain science into clinical reasoning and the integration of the biopsychosocial model into management and thinking is simply that a major goal for the patient is restoration of *thoughtless fearless movement*. Goal orientated movement is processed differently to pain focused/physically focused movement assessment.

The shopping basket approach

Changing thinking, reasoning and management approaches in never easy (see Muncey 2000). Just as established habits of movement and pain behaviour are difficult to change for many long term patients, so too are changes in our own "habitual" clinical reasoning and treatment approaches.

As already argued, the biopsychosocial model is a model for broader based thinking, it is multidimensional in its approach and seeks answers to pain and disability associated with pain, that are beyond the tissue and pain focused styles that many of us have been schooled in.

The "shopping basket approach" has evolved from my own analysis of how I think I think and reason with a patient. It may not suit everyone, but hopefully clinicians will find that it is simple and a useful way to see a bigger picture and possibly how a process of change is possible.

Whenever I see a patient, take their history and perform a physical examination, I start gathering information – I put it in the "shopping basket" and the shopping basket contains seven compartments:

- Compartment 1: Biomedical factors
- Compartment 2: Psychosocial barriers to recovery
- Compartment 3: Disability/functional limitations
- Compartment 4: Physical impairments
- Compartment 5: Physical fitness – general
- Compartment 6: Physical fitness – local
- Compartment 7: Pain

Each compartment will be discussed below and in part 3 of this series a patient example will be presented.

Compartment 1: biomedical factors

(See figures ...) See also the "Diagnosis section in part 1 of this series.

This compartment requires therapists to "think like a Dr *should*" based on the best and most recent information – and be able to answer the following:

- *Is the condition serious and require further investigation or appropriate medical management and intervention?* Therapists need to assess the "red flags" as written up in Waddell (1998) and Roberts (2000). The importance of therapists knowing how to assess red flags was emphasised in part one of this series.
- *Is the problem a common syndrome?* The reason for wanting to know this is that many presentations seen are clear cut and have well known natural histories. Some standard management protocols and treatments are available for many conditions. For example, frozen shoulder, wry neck, acute low back pain, hip OA, carpal tunnel syndrome etc. Clinicians need to be aware that many of the long established treatment protocols used for the management of these conditions have not necessarily got good support from clinical trials.
- *Is the nervous system competent?* This requires skilled and appropriate neurological testing.
- *Do you feel confident that the tissues that hurt or that may be responsible for the hurt are stable or strong enough to be progressively loaded? What tissue mechanisms are going on?* In part, the red flag assessment may help here. But time since the onset of the problem also tells us how long a healing process will have been going on. If we are to feel confident about getting people with pain moving and fitter we really want to feel confident that the tissues we are concerned about have a reasonable physical strength. Because the amount of pain a patient reports has so influenced therapists for so long the tendency is to hold back on function rather than keep it going or steadily increase from early stages. A great many of the "pre" chronic patients that I see are held back functionally because of an over-focus on being guided by the pain or on fears of re-damaging the tissues. Overcoming this difficult problem in a way that guides patients to increased function without fear or causing a set-back is a major part of the graded exposure approach to functional recovery (patient example, see part 3).
- *What pain mechanisms are operating and can they be considered adaptive/helpful or maladaptive/unhelpful?* The recent integration of pain science into clinical reasoning (Gifford 1997, Gifford & Butler 1997, Butler 1998, Jones et al 2002) allows us to reason the type of pain mechanisms that may be operating. For example, in

an acutely twisted ankle, although considerable neurochemical activity will be taking place in central, motor and sympathetic systems, the predominant cause of the pain is most likely due to intense activity in nociceptors serving the damaged tissues. By contrast, a patient with ongoing pain of 4 or 5 years following a road traffic accident is likely to have heightened sensitivity and reactivity of central nervous system connections and pathways and far less dominant nociceptive mechanisms. Clearly, pain and nociceptive activity in the twisted ankle can be viewed as an "adaptive" response of the tissues injured – if you like, the tissues, via the nociceptors, are screaming for help from the nervous system – their message reads "help me, do something will you, make him limp or take the weight off me, look after me, send me the paramedics ..." and as such this is a necessary and normal part of the injury and its healing. Note that even here, how the person *reacts* to the nociception and subsequent pain could well be maladaptive, for example they may not move the ankle, they may over-focus on the pain, constantly tending to it and rubbing it, they may rest it for days, limp too much and for far too long etc. It is here, very often, that inappropriate (maladaptive!) advice is often given by clinicians and others. How often have you seen patients with ankle sprains that have been told to rest, take pills and be guided by the pain? Isn't it harder the longer this type of behaviour has been going on? Very often the long immobilised tissues have become hypersensitive and stiff and the patient is very tense and fearful of movement.

In the second case, central activity and high levels of pain are likely to be considerably out of proportion to any remaining tissue abnormality, here the pain mechanism and the pain can be seen as much more maladaptive in nature. For the patient and the clinician it is helpful to understand that hurt does not equate with tissue harm or damage, and this new concept of pain needs to be taken on – by us, by medicine, and by our patients. Patients need to hear a consistent message from health carers, not different messages or conflicting ones. Great care must be taken not to dismiss pain that may be designated "maladaptive", high levels of pain are disturbing, unpleasant and often make life unbearable. To dismiss chronic, ongoing, high levels of pain as not being "harmful" or as being of no consequence is totally unreasonable. Recognising and feeling comfortable with maladaptive pain is a key issue and not at all easy – for patients *and clinicians*.

Please also note, even here, people can have chronic maladaptive pain but cope well with it and lead relatively productive and normal lives – even with maladaptive/useless/unhelpful levels of pain, people can lead functionally "adaptive" lives.

Compartment 2: Psychosocial barriers to recovery

As already discussed in part 1 (Gifford 2001), psychosocial factors have been shown to be vital considerations in predicting outcome from a musculoskeletal pain problem. Psychosocial factors are stronger predictors of outcome than any individual biomedical measures. For example a patient with a significant disc protrusion will not necessarily have a poor outcome. However, a patient with back pain who believes that any activity that provokes the slightest discomfort should be avoided and as a result rests and avoids activity a great deal, can be predicted to not get going, get back to normal activities or back to work as well as those who confront their problem and try to keep going. How a patient "ends up" is hugely determined by how they interpret and react to the situation they are in. Everyone tends to cope with their "pain" situation in different ways and some have more adaptive or maladaptive styles than others. Clinicians can have a huge impact on how well patients cope and how they recover, most especially early on. Be aware though, the impact can just as easily be negative – for example, erring towards fear of movement and over focus on pain, as positive, whereby functional confidence gradually gains momentum and the patient quickly gets back to normal activity.

Clinicians need to be wary of their own labelling, attitudes and assessment of a patient in terms of things like "psychogenesis" "malingering" or "over-reaction" for example. The plea, whatever you may want to think, is that the patient in front of you is what you have to deal with – their way of coping,

their way of behaving, their way of attributing, or blaming or understanding the problem they have. Further, if you understand these things and understand where the patient is coming from, you are more likely to be able to shift them towards a more productive way of thinking and dealing with their situation and hence positively influence their recovery and reactivation processes. Very often these types of "frustrating" patients have rarely had a fair hearing, have not been taken seriously or listened to and further dismissal or trivialising of their problem is likely to lead to more disability, more misery and demands for more investigations and treatments.

We also need to be aware that as time goes on patients who have not recovered are likely to have received a great many treatments that have been unsuccessful in fixing or relieving their pain and that failure of treatment causes disappointment and increased feelings of helplessness and hopelessness. Physiotherapists are urged to be more aware that largely passive approaches or approaches that are dominated with correction of one or two physical impairments given high significance, are the sorts of approaches that have come under criticism for being iatrogenic (disease or disability producing).

Further reading:
The assessment of psychosocial barriers is fully presented and discussed in the chapters by Paul Watson and Nick Kendall in:

Gifford L S (ed) 2000 Topical Issues in Pain 2. Biopsychosocial assessment. Relationships and pain. CNS Press, Falmouth.

Other highly recommended books:

Main C J, Spanswick C C 2000 Pain Management. An interdisciplinary approach. Churchill Livingstone, Edinburgh.
Waddell G 1998 The Back Pain Revolution. Churchill Livingstone, Edinburgh.

I believe that the psychosocial aspects of assessment and management are the most challenging area to take on for Physiotherapy. A personal comment, if it is helpful by being persuasive, – is that it has been two things for me – on one hand it has been the most exciting and most rewarding thing to understand and take on in my whole career as a physiotherapist – and on the other it has been the most difficult. Intuitive feel for a patients predicament is one thing, but understanding the *practical* ways in which a patients can be assessed and moved on is what is so highly skilled.

Readers are urged to study the references above and go on courses targeting skills in psychosocial assessment and management of pain using cognitive-behavioural methods. Bear in mind here, just as anywhere, that new fads are often pushed to "overkill" by enthusiastic believers! Look for a comfortable and well balanced presentation if at all possible.

The term "yellow flags" is perhaps the buzz word associated with the psychosocial factors that may be significant barriers to recovery. Briefly, the areas that can be assessed are divided into 7 groups, easily remembered using the headings *A B C D E F & W*.

It is important to bear in mind while conducting this part of our clinical assessment that a key question for the clinician is: "What can be done to help this person experience less distress and disability, get back to normal activities quickly and improve their physical confidence?".

"A" Attitudes and beliefs about pain

Pain associated with joints and muscles naturally causes guarding and care with movement. Rest and avoidance of movement is reinforced if activity hurts and resting is comfortable. Patients are often fearful of causing more pain or re-damaging or putting their problem back to "square-one". This is particularly so when patients have very high levels of pain or have had high levels of pain associated with the problem. Reducing the pain, if it can effectively be reduced, clearly helps (see pain compartment below), but often significant strides can be made if patients attitudes and beliefs about the nature of their pain or problem can be changed to a more positive one and which is less threatening.

Pain's primary purpose is to drive a change in behaviour – sometimes it demands rest and care with movement or exertion, but very often it demands that we move – the exact opposite. Staying still can hurt, moving makes you feel better. Being forced to stay completely still, to many, is a form

of torture. Pain by its very nature does not present a consistent message, and if you think about it, in the acute stages this is what the tissues actually need – a bit of take it easy go carefully, a bit of rest and looking after it if there's time and a bit of movement too. We have evolved to heal while still on the move, in nature pain sneaks in when it can and is quickly pushed out when life gets exciting. A major point is that survival dictates that rest has to be minimal, in nature not moving for long is not living for long. In contrast, modern living may give us too much free time – an amount never catered for during evolution! Pain has never had such a good opportunity as now!

There are many dimensions to this "doing nothing while it heals" mistake. Being unoccupied allows the brain to listen to the ongoing nociception coming in from the tissues and may reinforce it, especially if it is given high significance by the patient. How you interpret your pain dictates how it is processed by your brain. Remember, "gates" close to sensory information when our attention is focused elsewhere, when we are occupied mentally and physically. An individual that has little to do may well turn their attention towards their body so that even modest nociceptive activity can soon take a well established hold on consciousness in the form of pain. The longer and more continuously we are aware of pain, the more significance we give to pain, the more established and secure become the pain representational pathways within the brain and its consciousness "circuits" – and the harder they are to shift away. It seems that patients who do not understand their pain, who are fearful of it, who give it high significance, who are fearful of moving and who do not remain mentally and physically occupied from the early stages on, are biologically and psychologically giving pain a better chance of becoming permanently established.

The messages for us are simple – find out where the patient is coming from in terms of their pain – ask questions that relate to their perception of the pain, what it means to them about what they should or should not be doing, what they believe is wrong, how they see their future, whether they feel they have any control over their pain and whether they are keen to be actively involved in their own recovery.

Our patients words can be useful:

- "Understand your pain, see it as less threatening, start to see that you can move and get stronger even with the pain and your confidence grows, you see out of yourself, you don't notice the pain quite so much ... and then you realise that your pain has lessened! The most difficult part, but most helpful was learning how to pace activity and be gradual with exercises ..." (35 year old patient writing about her experience with 6 month old sciatica who had been off work and resting for the whole time and whose pain was gradually getting worse and worse).
- "The therapist frightened me, I was told that I had a disc derangement and that if the pain increased in my buttock and thigh I should stop what I was doing. I had difficulty doing anything! I also felt more upset after seeing her because she always looked so concerned about the pain and gave me the impression that my spine was going to breakdown if I bent or moved too quickly or coughed without holding onto myself. It seemed that the only thing that would protect me was if I could tense my stomach when I moved or coughed – it seemed so difficult and I just got tenser and tenser all over the more I tried ..." (45 year old policewoman with one year ongoing back and upper thigh pain).

I hope that clinicians can see that an important part of their "in-parallel" management is to understand and to then rework patients attitudes and beliefs about their pain if they are found to be unhelpful to recovery of function and restoration of physical confidence.

"B" Behaviours

This is all about what patients do or don't do, how they are responding to their pain, what they are avoiding and having difficulty with and how they react and report their situation.

It is hugely influenced by what they are told to do or not do by Drs., health care practitioners, friends, and magazine articles for example. Clear guidance is essential, but for far too long patients have been told not to do something or to avoid something – when at a future time it may well

be possible. Guidance needs changing as time proceeds.

Time and time again I find patients with knee problems relating to modest degenerate changes or medial ligament strains being told not to do breast stroke! Once someone has been told "never to do" or "not to do" something by someone with authority – it is very difficult to persuade them that it may be possible again – even if they take it on very gradually. One issue is that there is no evidence that breast stroke causes further knee damage or makes knee pain worse – another is that the only way to find out if it is possible is to gradually try it and find out. Most patients find it is possible. A rare few find that however gradually they try, it still does exacerbate their problem and that there is no way found round it so avoiding it has to be accepted. This example is only of modest consequences, but what if a back pain patient was told never to bend – like many so often are in the early stages of management. Fine to suggest care with some forms of bending to start out in the early stages perhaps, but surely bending confidence should be restored in a graded way at some stage? It is my belief that around 20 years of propaganda based on the disc derangement model and the concept of centralisation of pain relating to dubious biomechanical models for back pain has led to an unprecedented therapist fear of flexion that is passed on to patients (nice research project for someone!). Older therapists and those who have looked into earlier approaches to back pain will be aware that there was a time when the "Williams" lumbar flexion exercises were the "in" thing. A re-balancing focused on restoration of confident movement and multiple hypotheses that embrace broader dimensions of reasoning needs a far bigger voice. For example, increased emphasis on thoughts relating to central nervous system processing such as gating related to focus of attention, expectations, fear of pain or damage and changes in tension related to this.

This section brings our attention to how patients behaviour can effect the outcome and to how the management emphasis needs to be on reactivation, patient responsibility and the feeling of having control via active means, good pacing of activity, rest and exercise, and reduced reliance on passive therapy.

"C" Compensation issues

There are a great many clinicians who are quick to label the patient as "difficult to help" as soon as they find out that they are seeking compensation or that lawyers and disputes are involved. Compensation, disputes, financial hassles or medico-legal hassles certainly do not help, but to label patients quickly as "difficult" is to slip back into an "in series" single issue style of thinking. Far better to weigh-up all the other yellow flag factors and put in a bigger context before siding too strongly on a single issue. Far better to enquire as to the effect that the compensation/dispute/financial hassles may be having.

Quite often I have short sessions with patients with ongoing pains called "hassles that may not be helping". The word "hassles" is written in the middle of a piece of paper and the patient is asked to voice all the hassles that relate to their problem – as you jot them down. It's fun, the patients seem to enjoy it and constructive action plans usually evolve out of it. Calling the last consultant or therapist a "complete bastard" can sometimes be very therapeutic, more especially if the patient can come round to seeing why the clinician might have responded in the way they did. A major goal is to discuss what happened, with the aim of putting the experience into a less tension creating context. In this way the patient can start to learn the skills of re-evaluation of the very things that get to them.

Hassles often create tension, anger, frustration, and patients can spend many hours dwelling on them – a common one is the half a dozen or so words that they remember from the last consultant – "get on with your life there's nothing wrong with you ..." Or the report they've just had for their litigation that virtually denies they have a problem. Having your veracity challenged is very disturbing. Many patients have run out of ways to know how to explain or show the reality of their problem. How can they get well unless they are believed by those who they feel should know better?

Once all the "hassles that are not helping" have been written on the paper I might ask the question – "Is there anything you think that could be done to lessen these hassles?"

I get another piece of paper and we list the ones that can be worked on.

We might get a long list of things.

At the top might be "responding to the inconsistencies in the last consultants legal report" – he's been putting it off for ages, the solicitor is hassling him and he keeps churning it over in his mind because it made him so angry and he doesn't know how to find good enough words to express his situation or his feelings. I get him to have a go – I make some suggestions and the process continues until it's done and ticked off the list.

We do one thing at a time and when it gets done it gets ticked off the list, we start with the most annoying and we may just do a little of that until it is eventually done. The patient learns to put a small part of the day aside for "dealing with hassles". We both problem solve the hassles and the patient learns how it can be done. Often the patient feels better because they're getting a sense of control, they're seeing the light at the end of the tunnel, they're able to respond to things in a balanced way and get them done before they become a burden.

Some hassles are difficult to deal with. For example, "the bloke who hit me, who smashed my car up and left me like this, he never said sorry, he didn't even offer to help me ... he's now denying it was his fault!"

We can't deal with patients lives, we all have hassles, but we can take one or two, show how they can be better managed and teach the skills to our patients. But we must be careful not to take over.

"D" Diagnosis and treatment Issues

There is now a good body of evidence to show that what clinicians/medicine says to patients may help to create the conditions that lead to long term incapacity. For example, complicated language and diagnoses, conflicting diagnoses, explanations that create notions of physical weakness and frailty or long term incapacity (you've a spine of a 70 year old ...), dramatic explanations of pathology, and salesman approaches to therapy that raise expectations of a quick and easy cure.

Ask the patient, find out what they have been told, what it means to them, what they think of their previous treatments and management and what their role has been in it all. Ask them what they want from you – what are their expectations? A great many patients merely want some kind of better understanding of their problem and advice about how to deal with it themselves, yet get hooked on regular long term treatments and follow ups quite unnecessarily.

The message here is clear – listen to what the patient has been told, think about its detrimental effects, avoid rubbishing others efforts, try and steer the patient towards more positive confidence building information that makes sense and that fits with a reactivation approach and check what the patient understands from what you have said. Above all, try and shift the patient from being fearful of structure, having the notion that there is a passive fix for their problem, to one that engenders more responsibility and a gradual return of physical confidence. Positive information is one thing that helps a bit, but starting to get a few movements going and gradually building from a sound confident baseline is ultimately the thing that supports the veracity of the information and gets the patient back into life again.

"E" Emotions

Most people with pain feel fed up. Fed up with the pain and fed up with the negative spin-offs associated with it. The longer a pain goes on the more fed up we tend to become. For some patients merely being fed up and frustrated can develop into increasing levels of distress and sometimes clinical depression. When people feel down they tend to change routines and habits, they may stop socialising sometimes to the point that they feel a bit anxious about mixing with people, they feel less inclined towards physical activities, they lose self esteem, feel hopeless and helpless and sometimes take great deal less care of themselves. It can be very difficult to motivate people to get going and get fitter or become actively involved in their own management when they feel miserable, distressed or depressed. Sometimes people can snap out of the situation they are in, make a big effort and turn a corner, but often they wallow on occasionally dragging themselves up, but soon drifting back into unhealthy routines and behaviours that require little effort. Change requires a great deal of effort and when you are low effort is very difficult to sustain.

Patients who are significantly distressed or are suffering emotionally are difficult to manage on a

one to one basis in Physiotherapy departments. It is no wonder that patients who have a significant degree of distress, have a poorer outcome and are harder to help. If I really think about many of the patients that I have treated in the past who have been really difficult I have to acknowledge that my awareness of their emotional state, there concerns about their situation, their levels of stress, their interest in themselves or their level of socialising – were things that I had never given hardly a thought to, but if I had I am sure I would have a better insight into why they were so problematic.

Many patients have all sorts of hassles and problems going on in their lives, physiotherapists are not trained councillors or psychologists and it is not our place to deal with these areas. However, many patients with pain are low in spirits because of the pain and the problems that they have encountered as time has gone on. Getting patients involved in taking responsibility, reassuring them about their pain and getting them to tackle and reach a few simple physical goals are the sorts of things that can help them turn a corner, pick themselves up, start to improve their self esteem and confidence and move forward.

"F" Family

This is a very interesting area and one which has been discussed in detail in chapters 6 & 7 in Topical Issues in Pain 2 (Gifford 2000). The reaction of family and friends can often have a big impact on how the individual reacts and feels. Families may become very protective and fearful for the patient – reinforcing a "be careful don't move" style of coping while at the same time taking away responsibilities and making the patient feel hopless and useless. It is easy to ask the patient how their family may be reacting to their problem as well as to include them in the rehabilitation process.

"W" Work

As discussed above, doing nothing or being unoccupied is detrimental to recovery and ultimately detrimental to an individuals health. It is also detrimental to business, to the economy and the nations health. It is where pain and disability from pain meet politics. Since the early 1980's the number of people not working due to back pain has risen at an alarming rate. The graphs are everywhere and represent increasing *disability* in Western society from a disorder (back pain) that is just as prevalent as it always has been (Waddell 1998). Back pain has not increased in prevalence, but disability from it has. Increasingly sophisticated physical therapy, surgery and drug therapy has had no impact on the tragic and unnecessary disability curve.

Getting people back to work or keeping them in work if at all possible should be a major goal of physiotherapy. The barriers that prevent people from returning to work come under this "W" category. The patient's work situation needs our understanding, it has several dimensions which are dealt with excellently by Main and Burton ((Main & Burton 2000)). Two will be discussed briefly here to whet the appetite for their chapter!

- *Physical factors?:* – clearly if a patient's work involves heavy physical activity with little opportunity for changing conditions, return to work may be more of a problem than if the work was less strenuous or more flexible. However, with regard the "physical" dimension of injury and disability, therapists need to be aware that traditional thinking – that there is a direct relationship between the physical demands of work and the occurrence of injury – is not well supported by the scientific literature and is quite complicated. While a great many "perceive" that their problem was related to work the evidence seems to suggest that although the back can certainly be injured in various ways, the "injury model" is not able to explain the wide variation in resultant disability. The important issue to grasp is that the *initial* occurrence of back pain may well relate to physical stressors but *recurrence and disability* are mediated more by psychosocial phenomena.
- *Work stress – blue flags!:* How an individual *perceives* their work is of such significance it has now been given its own coloured flag – blue (Main & Burton 2000). Patients may be wary of returning to work if they *perceive* that their work is physically demanding and likely to re-injure them. There are many other "blue" factors too, for example, return to work is less likely if patients don't like their work, if they

see it as repetitive and boring, if there is little satisfying about it, or it is too pressured with poor rewards and meagre support from managers or colleagues, or if they have little control at work, there may be conflicts with colleagues. Clearly, issues like these, and ones that many of us will think are obvious, are significant barriers to getting people back to work. Human nature very often follows a simple law of all nature – that is, to get as much as you can for the least amount of effort!

If we are to help in getting people back to work, or help them to stay at work, we need to understand their work situation, how they perceive their work and their relationship with their work colleagues as well as the attitudes and beliefs about the causes and nature of their problem.

Care with the Yellow flags …
All patients, whether acute or chronic have some yellow flags. The more that are present or the higher the scoring on the "Yellow flag" questionnaire, the more strength with which a poor outcome can be predicted.

Three issues are important here. Firstly, it is unfair to label a patient as being difficult based on one or two positive findings. For example, as already discussed, patients who are involved in litigation or compensation are often blindly labelled as no-hopers and given little credibility. Careful assessment of other areas may well indicate good potential for recovery or a specific management need.

Secondly, the identification of significant yellow flags helps direct management to give attention to the identified barriers/problems. For example, a patient may believe that their pain indicates major structural damage or disease that has not been found. Time taken with history taking and a thorough physical examination accompanied by a reassuring discussion regarding the nature of the injury and pain may make a positive impact here. "Structural reassurance" however, can only be achieved if therapists know their "red flags" and have fully assessed them (giving confidence that nothing serious is wrong structurally or pathologically). The development of a high competence in assessment needs to be paralleled by a high competence in *explaining clearly* in terms that the patient understands and which has a useful and positive message. In my opinion this is a hugely under-practised area of pre and post graduate training, and it is so easy to get wrong and very difficult to get just right.

Thirdly, high "yellow flag" scores should not mean that physiotherapy is inappropriate. However, it may mean that far better outcomes will occur if the patient is managed using a multidisciplinary team approach. The current growth in the number of high quality pain management units utilising cognitive behavioural principles is a very positive step.

Good clinical reasoning is all about picking out all the issues and then being able to prioritise them – dealing with the most important findings and issues first. Quite often significant yellow flags need addressing before any "physical progress" can be made.

Compartment 3: Disability/functional limitations

From my own clinical reasoning perspective, I see disability/functional limitations as "what the patient reports they have difficulty doing, or cannot do, as a result of their pain problem.

Disability may relate to "activities" – like walking, housework, lifting, sport etc.

Or it may relate to "inactivities" like sitting, standing or lying.

During the clinical interview I put emphasis on finding out what the patient is doing now compared to what they normally do, what they feel they could do and what they want to get back to (see "B" Behaviour section above too – there is overlap). The barriers to them getting back to doing those things need assessing and understanding too.

Because I was so schooled in a biomedical/in-series/single tissue style of approach, getting the patient to start working on avoided activities was often left a long way down the management priority list or given little real focus of attention. I wasn't that interested, perhaps it wasn't really intellectually stimulating enough and if I am honest, the thought of function mucking up the pain after all those treatments was very off-putting! I thus didn't really have a clue about how to constructively get the patient back into activity in a way that didn't stir everything up again.

Having now seen a great many patients who are well down the chronic disability pathway it seems quite obvious that in the early stages their disability could have been prevented if earlier activation had occurred. In part 3 of this series the patient example is typical of these patients and clearly demonstrates that a "graded exposure" style of approach to functional confidence is probably the most important and useful tool that good rehabilitative physiotherapists have to offer.

Compartment 4: Impairments

Impairments are the things that physiotherapists find during the physical examination. Thus, loss of range of joints, muscles, nerves, motion segments, hypermobility, sensitivity to movement or palpation, weaknesses, altered movement patterns, altered reflexes, physical asymmetry, altered anatomy etc.

This is the area that many physiotherapists have become experts in. We love our complicated instability tests, our neurodynamic tests, our muscle tests our joint accessory movement tests and so forth. The problem is that the evidence at this stage is not that supportive for the importance of impairments in relation to pain, function and disability. Far more evidence supports compartments two and three above and these therefore, in most cases, should head the management priority list *before* getting down to the impairment nitty-gritty.

I am not against these skills, but I am concerned that a great many put a great deal of emphasis on them at the expense of other compartments.

On the more positive side however, a good physical examination is a very reassuring thing for the patient, focus on improving impairments is often a useful tool in reactivating the patient and can help alter pain. So long as we are aware of the dangers of physically over-focusing, of the patients potentially negative interpretation of what we uncover and explain and that the explanations associated with tissue abnormalities have weaknesses then we should be comfortable here. Most importantly, if at all possible patients should be given the tools and the responsibility to work on the impairments themselves, rather than being reliant on the therapist.

Compartment 5: Physical fitness – general

All of us will be aware that being physically fitter feels good. Physically fitter people tend to cope better and manage their lives better than unfit people. Clinicians will know of many patients with ongoing pain who have significantly moved on or improved once they started to get fitter and as a result feel more in control.

Patients with significant pain often get frustrated with the lack of exercise, many become deconditioned and become more moody as a result. Pain and low mood leads to "bad behaviours" – over-indulgence, lack of activity leading to even lower mood, poor sleep, and the emergence of other physical symptoms.

Graded physical fitness programmes are a very important part of management at an appropriate stage, or may even be a key component of recovery early on.

It is quite simple to ask patients how fit they feel now compared to before their problem or whether or not they feel as fit as they would like to be. Assessment of function can often be linked with assessment of fitness.

This section will be explored further in part 3 of the series.

Compartment 6: Physical fitness – local

The long standing biomedical reasoning models used in physiotherapy have consistently directed us to managing a presumed "source" of the pain or problem. For example, a pain down the leg deemed to be coming from the back resulted in therapy and exercises to the back, even though there may well be quite significant impairments/deconditioning in many of the tissues in the leg as a result of the pain.

This compartment is a plea for clinicians to think beyond the hypothetical sources and causes of the pain and address the tissues affected by the problem too. Patients with referred pain into the leg often have stiff and painful peripheral joints or demonstrate loss of power and endurance in related muscles. Progressively working and moving these tissues, especially in a functional way, may well trigger a biological message of recovery that says "we need you, improve your function" and then the later retort from the nociceptive and nervous system that goes "we feel safer, we will decrease our sens-

itivity now". A key paradigm might be that a weak organism "senses" its own vulnerability and hence up-regulates levels of sensitivity, whereas a stronger organism "senses" less vulnerability and as a result lowers the sensitivity setting. Local fitness management of tissues that either contain the pain, are affected in some way by it, or that may in part influence it, are all worthy of some input.

A significant step forward in improving confidence is to activate the areas the patient feels vulnerable in – and this is often the area that they think the problem is coming from as well as the areas where the pain is felt when there is referred pain.

Compartment 7: Pain

Pain is at the end because it has been at the beginning for so long. It is still important and is of course the primary reason for the patients problems and their suffering. If pain relief was more effective the whole process would be so much easier. While the most recent findings of research urge us to be very cautious in over focusing on pain that does not mean it has to be forgotten. If we can relieve it fine, but if we are making patients dependent on therapy then there is something wrong unless we are merely in this for economic gain.

A major aim is to help to get the patient involved in managing their pain better. This often means adequate pacing of rest and activity; exploring movements and resting postures that may help. As argued earlier, there are a great many pain "treatments" available – from magnetic and copper bangles to sophisticated medicines and surgeries. What is clear is that there is always something out there that can help a bit and occasionally a lot – which presses us to be open to any possibility that may help. Everyone has their personal style, their favourite techniques and their favourite beliefs. I would simply urge that physiotherapists involved in the management of patients pain see the importance of self management and patient responsibility if at all possible.

The final part of this series takes a patient example using "graded exposure" principles of management. Hopefully the case will demonstrate many of the issues discussed in this and the previous articles.

Further reading:

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Referat fra møder i IFOMT

Estoril, oktober 2002

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I forbindelse med kongressen »Touch our Minds« blev der holdt to møder. Derudover var der rig lejlighed til at diskutere manuel terapi på internationalt plan med de øvrige delegerede i IFOMT. På det lukkede IFOMT-ECE-møde for delegerede var der få punkter på dagsordenen, og det var i forvejen fastlagt, at der ikke ville blive taget referat af mødet for at få en mere fri debat.

IFOMT arbejder i øjeblikket ud fra en 5-punkts strategiplan. I det følgende skitseres kort de enkelte områder, formål inden for disse og status i oktober 2002:

Inden for *ressource management* er formålet at forbedre hjemmesiden og at forbedre de økonomiske muligheder gennem medlemskontingent, annoncering og flere medlemmer. Ligeledes er det formålet at øge aktiviteten i de enkelte medlemslande. Hjemmesiden blev diskuteret med henblik på forslag til indhold. Den canadiske gruppe arbejder med sagen.

Inden for *PR og kommunikation* er formålet at fremme IFOMT's image samt at etablere et effektivt internt informationssystem og udvikle en marketingsstrategi. Også her arbejdes der via websiden i øjeblikket.

Inden for området *akademiske standarder* er formålet at fremskynde implementering af uddannelsesmæssige standarder, at udvikle et ressourcecenter med et »buddy system« for nye og kommende medlemmer. Der skal udvikles procedurer for revidering og evaluering af standarder i de enkelte medlemslande, og der skal sikres en kontinuerlig udvikling af IFOMT-standarder. Der er annonceret efter eksperter, som skal indgå i ressourcecentret.

Inden for strategiområdet *uddannelse* er formålet at etablere et uddannelsesressourcecenter, at definere specialisering og at fremme det bevægelige arbejdsmarked for manuelle terapeuter. Der er gennemført en rundspørge blandt medlemslandene for at få klarlagt, hvordan MT-uddannelse er rangeret i de enkelte medlemslande. Resultatet af denne undersøgelse blev fremlagt på det åbne møde i Estoril og fremgår herunder.

Inden for *forskning og evidensbaseret praksis* er formålet at etablere en IFOMT-forskningskomité og at etablere og promovere forskningsbevidsthed og forskningssamarbejde internationalt mellem medlemmer. Dette skal ske gennem et web-baseret ressourcecenter. Status november 2002: Der er annonceret efter nationale ressourcecentre i medlemslandende. Det meningen at disse skal indgå i det web-baserede center og på den måde fungere som internationalt netværk.

På det åbne møde præsenterede to ansøgerlande, Irland og Spanien, deres manuel terapi-programmer. Den belgiske gruppe introducerede et kvalitetssikringssystem og et reklamefremstød, som vakte nogen forargelse, måske lige bortset fra i den belgiske gruppe.

Marina Wallin, fra Sverige, havde gennemført en undersøgelse af de uddannelsesmæssige standarder inden for manuel terapi i de enkelte medlemslande. Resultaterne blev fremlagt, og det viser sig, at der er meget stor variation i den uddannelsesmæssige standard fra land til land.

Antonio Lopez, fra WCPT-Europe, gennemgik en rapport som er udarbejdet i dette regi. I denne rapport er hvert enkelt EU-lands (og i øvrigt også andre europæiske landes) uddannelsesmæssige baggrund beskrevet, således at det er muligt at sammenligne standarder. I denne rapport er der en lang række definitioner af f.eks. en specialist, som er meget vigtige i forhold til internationalisering af uddannelser og sikring af arbejdsmarkedets frie bevægelighed. WCPT har en strategi omkring et transfer-system mellem landene, som skal være implementeret i 2010.

Mødet blev afsluttet med en noget tam paneldiskussion.

Det overordnede indtryk fra IFOMT-møderne var, at der nu arbejdes seriøst og målrettet efter en fornuftig strategi. Formanden, Agneta Lando, bærer en stor del af æren for det, sammen med IFOMT's bestyrelse. Det skal blive spændende at være med til at føre de forskellige strategier ud i livet. Danmarks delegerede, som er forfatteren til denne artikel, sidder i den gruppe som arbejder med uddannelse. Gruppen består af den svenske repræsentant Marina Wallin, finske Maarit Keskinen og undertegnede.

Bedre lindring af nakkesmerter

Manuel terapi giver bedre lindring af nakkesmerter end fysioterapi eller behandling hos praktiserende læge

Christian Couppé

Sammendrag

Hoving J, Koes B, de Vet H, van der Windt D, Assendelft W, van Mameren H, Deville W, Pool J, Scholten R og Bouter L (2002). Artikel: Manuel terapi, fysioterapi eller behandling af praktiserende læge for patienter med nakkesmerter. Et randomiseret kontrolleret studie. Annals of Internal Medicine 136: 713-722 (Sammendraget er efter Chris Maher, redaktionsmedlem ved Australian Journal of Physiotherapy i samarbejde med Fysioterapeuten i Norge).

Problemstilling
Hvilken behandling er mest effektiv for nakkesmerter; manuel terapi, fysioterapi eller behandling hos praktiserende læge?

Design
Randomiseret studie med skjult randomiseringsprocedure.

Sted
Holland.

Patienter
183 patienter i aldersgruppen 18–70 år, med nakkesmerter. Inklutionskriterier var nakkesmerter eller stivhed i mindst to uger, nakkesmerterne kunne reproduceres ved fysisk undersøgelse og at patienten ikke havde modtaget manuel terapi eller fysioterapi de sidste seks måneder. En patient mødte ikke op til re-test efter syv uger.

Intervention
60 patienter blev fordelt til manuel terapi, 59 til fysioterapi (undtaget manuel terapi) og 64 til almindelig lægelig behandling. Manuelterapien bestod af op til seks 60-minutters behandlinger som kunne inkludere bløddelsbehandling, specifikke ledmobiliseringsteknikker, koordinations- eller stabiliseringsøvelser, men ikke manipulation. Fysioterapien bestod af op til 30-minutters behandlinger med aktive øvelser. Manuel stræk/traktion, massage eller andet kunne gå forud for øvelserne. Praktiserende læge- gruppen modtog standard behandling som kunne inkludere råd, vejledning og medicinering.

Effektmål
Hovedeffekten var: 1) »godt behandlingsresultat« defineret ved at patienten beskriver sin tilstand som rigtig god eller meget bedre, 2) forskers måling af fysisk dysfunktion (skala 0 = ingen fysisk dysfunktion, 10 = maksimal dysfunktion), 3) besværlige smerter, gennemsnitlige smerter og største smerter målt på en 0–10-skala, og 4) funktionshæmning målt med »neck disability index« (skala fra 0 = ingen funktionshæmning, 50 = maksimal funktionshæmning). Opfølgningstiden var syv uger, resultaterne blev målt blindet og analyseret i forhold til »intention to treat«-princippet.

Resultat
Ved syv uger var der en statistisk signifikant større andel af deltagerne i Manuel terapi-gruppen (68%) som havde positiv effekt end i fysioterapigruppen (51%) eller praktiserende læge-gruppen (36%). Manuel terapi-gruppen havde større bedring end praktiserende læge-gruppen for fysisk funktion (between-group difference og 95 procent CI 1,7 [0,9-2,5]) og for alle tre smertemål (for eksempel besværlige smerter 1,5 [0,4-3,5]) men ikke for funktionsniveau 1,9 point (–0,3-4,1). Sammenligning af manuel terapi versus fysioterapi og fysioterapi versus praktiserende læge gav forskelle mellem grupperne som var små og/eller ikke statistisk signifikante.

Konklusion
Patienter med nakkesmerter som får manuel terapi har større sandsynlighed for at rapportere at deres tilstand er blevet god eller bedret end dem som har fået fysioterapi (uden manuel terapi) eller behandling hos praktiserende læge.

Kommentar

Studiet er interessant, men Nick Bogduk har efterfølgende fremkommet med disse væsentlige kommentarer til studiet:

To besøg hos praktiserende læge kan knap nok siges at være tid nok til at vurdere patienten og skrive en recept. Man bør derfor være opmærksom på hvor gode og overbevisende råd om prognose, råd om psykosociale tiltag, råd om ergonomi og opmuntring til videre bedring har været i dette studie. En kynisk forståelse af resultaterne i dette studie kan være at manuel terapi er bedre end suboptimal behandling hos praktiserende læge. Det er ikke det samme som at bevise at manuel terapi »virker«. Det virker bare bedre end halvt så god medicinsk behandling. Et mere udfordrende studie ville være at lade praktiserende læge give en bedre intervention ved at have 3 til 6 konsultationer. Det studiet peger på er, at manuel terapi er bedre end det praktiserende læger giver af tilbud i dag.

Referat fra Manuel Terapi-kongres i Estoril

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fysioterapuet, DipMT, MSc, ph.d.-studerende

Som den første internationale kongres afholdt af den portugisiske manuel terapi-gruppe må man sige, at det var et meget vellykket arrangement. Til trods for en række spændende foredragsholdere, var det kun lykkedes at tiltrække godt 100 deltagere. Derfor blev kongressen holdt på et hospital i udkanten af Estoril, og for at fylde lidt op på de tomme pladser var de fysioterapeutstuderende på dette hospital inviteret med. Temaet for kongressen var som titlen antyder: »Touch our Minds« og der var programsat 30 indlæg. Der var meget fokus på patientperspektivet og klinisk ræsonnering fyldte meget. I det følgende har jeg valgt at referere de indlæg, som efter min mening har størst klinisk relevans.

Det første indlæg blev afholdt af Ann Moore, professor ved Universitetet i Brighton. Titlen var »patientens perspektiv på lænderygbesvær«. I forhold til patienten var der fokus på en lang række faktorer som spiller ind ved lænderygbesvær såsom evidensbaseret praksis, patientens oplevelse og forventninger til behandling, og endelig relationen mellem behandler og patient.

Ann Moore refererede en kvalitativ undersøgelse på 8 akutte og 8 kroniske patienter med lænderygbesvær. Ved hjælp af interview fandt man ud af, at patienternes forventning er, at der stilles en diagnose, at der gives gode råd, at en behandling stilles i udsigt, at der opnås en forståelse for den sundhedsprofessionelles rolle, at der opnås en vished for, hvad det drejer sig om, og endelig at der opsættes mål. Hendes konklusion på undersøgelsen var, at det er yderst vigtigt for terapeuten at kende patientens forventninger, at der er tid nok, at kommunikationen er entydig, så patienten er helt klar over, hvad der kan forventes. Den sidste del af foredraget refererede forskellige arbejder, som understøtter at behandling lykkes bedre, når patienten er aktivt involveret, og der findes en velfunderet relation mellem terapeut og behandler.

Det følgende foredrag blev også holdt af Ann Moore på grund af afbud. Hun refererede en randomiseret, klinisk kontrolleret undersøgelse som er publiceret i Lucy Goldbys ph.d.-afhandling fra 2002. I studiet blev 346 patienter med kronisk lænderygbesvær inkluderet og 303 deltog. De blev randomiseret til hhv. manuel terapi, stabiliserende øvelser og pjece. I gruppen som fik manuel terapi blev denne givet på baggrund af terapeutens kliniske ræsonnering, og der måtte ikke gives øvelser til m. transversus abdominis eller mm. multifidii. Stabiliseringsgruppen fik forevist en video mange gange. Der var tale om 6 øvelser med fokus på træning af det aktive sub-system af muskler. Der blev trænet i grupper, hvor man hjalp hinanden. Den sidste gruppe fik en pjece at læse i. Resultaterne var, efter 75 droppede ud af undersøgelsen, at efter 6 måneder havde stabilitetsgruppen signifikant større smertelindring og efter 12 måneder også bedre funktion. På alle målte effektparametre var der en trend mod bedre resultater i stabilitetsgruppen men ikke signifikant. Studiet svækkes af mange dropouts specielt i pjecegruppen. Studiet er ikke publiceret i peer reviewed-tidsskrift.

Nicola Petty holdt et indlæg om Maitlands graduering af bevægelse og modstand. Hun gennemgik bevægelsesdiagrammet og de problemer, der er med reproducerbarhed af disse. Det har hidtil været antagelsen at der i begyndelsen af en bevægelse, hvad enten den er accessorisk eller fysiologisk, ikke er nogen modstand og at denne, R1, først sætter ind senere for at stige eksponentielt. For at validere bevægelsesdiagrammets udseende med det flade tåparti, målte man kraftudviklingen via en trykplade, når der blev appliceret en maskinel udviklet kraft på L3, et ankelled og et skulderled. Det viste sig, at så snart kraften appliceres begynder modstanden at udvikle sig, og det gjorde den lineært uanset hvilket led, der var tale om. Den kliniske konsekvens af dette er, at når vi taler om at mobilisere i grad 1 eller grad 2 uden modstand, så er det ikke sandt. Der er modstand. Det vi klinisk har kaldt R1, den første modstand, må derfor være et udtryk for det punkt, hvor vi kan begynde at registrere spænding. Det kan jo være med til at forklare, hvorfor det er så svært at blive enige om hvor R1 ligger henne.

Kareen Beaton holdt et indlæg om cervikal instabilitet og gennemgik anatomi, patologi og de mere eller mindre kendte test. En litteraturgennemgang viste, at kun sharp purser-test var valideret,

men det var gjort på patienter med RA. Konklusionen var, at der er meget lidt evidens for at mindre grader af instabilitet i cervikal columna eksisterer.

Susan Mercer refererede sit kadaverstudie på thoracal columna og især discus intervertebrale. Det interessante var, at nucleus her har en anden konsistens, end lumbalt. Opadtil er den fibrocartilaginøs for at blive mere og mere blød nedadtil. Der, hvor costa mødes med discus, er der ingen annulus.

Catherine Doody holdt et indlæg omkring klinisk ræsonnering hos 10 eksperter i manuel terapi i sammenligning med 10 novicer. Det var et observationsstudie, hvor der blev brugt direkte observationer på undersøgelse og behandling af patienter, video, feltnoter samt interview. Man havde specielt fokus på om terapeuterne benyttede ICIDH- og ICD-klassifikation og -diagnoser. Ifølge undersøgelsen opsatte alle fysioterapeuterne flere hypoteser. Eksperterne opsatte deres hypoteser hurtigere og havde oftere allerede inden den kliniske undersøgelse en diagnose. Derimod nåede novicerne først sent i undersøgelsen frem til en diagnose. Konklusionen var at diagnostisk ræsonnering bør introduceres allerede i fysioterapeutuddannelsen. Et meget lignende indlæg blev holdt af Eduardo Cruz.

Jane Greening holdt et blændende indlæg omkring de neurogene, patogene og smertefysiologiske elementer ved mindre nervelæsioner opstået som følge af vedvarende tryk eller repetetive belastninger. Ved hjælp af ultralydsoptagelser så vi, hvordan n. medianus hele tiden bevæges ved museklik både i aksiale og longitudinelle snit. Ikke underligt, at det nogen gange giver problemer. Hun påviste, hvordan n. medianus bevæger sig ved respiration hos ikke symptomatiske individer, og hvordan bevægelsen er hæmmet hos patienter med diffuse armsmerter. Ud fra dette opstillede hun en hypotese om sammenhæng mellem smerte og nedsat mobilitet i nervevævet. (Lynn et al, 2002; Greening et al, 2001).

Det sidste indlæg som jeg desværre kun hørte halvdelen af var af Mark Comerford. Det meste var en lang opremsning af evidensen for ideerne om segmental stabilitet og mangel på samme. Det samme kan læses i Comerford og Mottrams artikel i Manual Therapy fra 2001.

Der var som nævnt i indledningen 30 indlæg og jeg har valgt at referere bare nogle få, men betydningsfulde af dem. Alt i alt synes jeg at den portugisiske manuel terapi-gruppe fortjener applaus for deres vellykkede arrangement. Synd at der ikke var flere deltagere, men en anden gang kan jeg kun opfordre til at drage til Portugal til kongres. Der er jo også andet end lige kongressen, f.eks. portvin, strand og 20 grader i slutningen af oktober.

Dansk Selskab for Muskuloskeletal Medicin Columnaprisen

Dansk Selskab for Muskuloskeletal Medicin har indstiftet en pris, der uddeles en gang årligt til en dansk forsker, der har præsteret et vigtigt videnskabeligt arbejde inden for hvirvelsøjleforskning og dermed beslægtede emner.

Prisen er på kr. 15.000 og kan eventuelt deles. Uddelingen finder sted ved den årlige ordinære generalforsamling, og det forventes, at modtageren af prisen præsenterer sit videnskabelige arbejde for selskabets medlemmer.

Indstillingen til prisen foretages blandt videnskabelige arbejder inden for hvirvelsøjleforskning og dermed beslægtede emner, der er egnede til publikation, respektive er publiceret i »Peer-reviewed« nationale eller internationale videnskabelige tidsskrifter.

Ansøgningsfrist med henblik på bedømmelse af arbejderne er den 31. december i det år, der er forudgået af prisuddelingen.

Arbejder der ønskes bedømt mhp. tildeling af Columnaprisen, bedes sendt i 4 eksemplarer til formanden for Videnskabeligt Udvalg under Dansk Selskab for Muskuloskeletal Medicin:

Overlæge, dr.med. *Lars Remvig*,
Klinik for Medicinsk Ortopædi og Rehabilitering,
H:S Rigshospitalet 7611, T9,
Blegdamsvej 9,
2100 København Ø,

senest den 31. december 2003.

BOGANMELDELSE

Physical therapies in sport and exercise

Christian Couppé

Gregory Kolt, Lynn Snyder-Mackler, Churchill-Livingstone
2003, 644 pp, Hardback, 450 illustrations, 60 £
ISBN: 0443071543

The contributing authors are world leaders in their respective fields and include mostly clinicians, but also researchers.

The purpose of this book is provide physical therapist and other rehabilitation specialist with how to management injuries in sport and exercise.

The text is divided into five parts and here I will describe what I think is the best in this book:

1. Section 1, *Management Principles for Muskuloskeletal Tissue in Physical Therapies*. This section deals with five groups of body tissue: muscle, tendon, ligament bone and nerves. These chapters provide coverage of the basic structure and biomechanics of the tissues, the principles relating to the adaption of the tissue to mechanical load, and response of the tissue to injury and healing.
2. Section 2, *Concepts in Managing Sport and Exercise*. The Chapter in this section provide general information that is important in the mangement of injuries from various regions in the body. Motor Control, covers the theory an d appliction of motor control and relearning in the management of sport and exercise related injury. Pain, outlines the mechanisms and theories of pain perception, and presents strategies to assess and manage pain from both physical and cognetive/behavioral perspective. Exercise-based Conditioning and Rehbilitation, outlines the evidence for the use of varoius forms of exercise in injury prevention and and management. Psychology of injury and rehabilitation, works through Psychological factors that affect the onset and rehabilitation of injury. Also, issues related to rehabilitation adherence and the role of physical therapist in applying basic cognitive/behavioral techniques are covered. Screening Sport and Exercise participation focuses on the principles and practical application of screening procedures that are used for sport and exercise participation. Issues related to general health and sport specific helath fitness are adressed. Out come Measures in Sport and Exercise Physical Therapies, covers a range of outcome measures that can be used in sport and exercise physical therapies. This adresses the both clinical measures and condition specific measures. Electro Agents in Sport and Exercise injury management, evaluates, from a scientific perspective various electrophysical agents commonly used by sport physical therapist. The emphasis is on outlining the evidence to support or refute the role of such modalities in sports medicine. This chapter was in someway disappointing by one of the absolute world leaders in the electrotherapy field and suffered from lack of depth.
3. Regional Sport And Exercise injury management. The 10 chapters in this section deal with the Spine, Shoulder, Elbow, Wrist and Hand, Pelvis and Groin, Thigh, Knee, Patellofemoral Joint, Leg, ankle and foot. In each of these chapters the content focuses on sport/specific applied anatomy, examination, and the management of common and less common sport and exercise related injuries to the region.
   I really enjoyed reading the chapter by Reinold and Wilk covering the chapter of the elbow with in-depth and systematic information in how to manage the elbow.
4. The last to sections covers the role of sport and exercise and physical therapies in active groups such children older participants, active females and Medical Considerations for rehabilitation practitioners in sport and exercise settings like pharmacological agents, drug on the athlete's health and well/being.

In Summary, the text is very well written, with adequate illustrations and tables.

The organization of the text follows a logical order of progression and encompasses a variety of topics that are very relevant to the field of physical therapy.

I highly recommend this book to all physical therapist and physicians. Other health professionals, such as athletic trainers, and exercise physiologist would find this book appropriate for their libraries.

However, this book does not replace tomes like Nicholas and Hershmans volumes on the upper and lower extremities, rather, the intent is to serve as a practical induction into properly caring for the special athlete who competes at any level.

Generelt for kurserne

Sted: Comwell Kolding, Skovbrynet 1,
6000 Kolding. Tlf. 76 34 11 00.

Kursusafgift: Er anført under de enkelte kurser. For kursister, som ikke er medlem af DSMM, Danske Fysioterapeuters Fagforum for Muskuloskeletal Terapi eller McKenzie Institut Danmark, vil der være et administrationsgebyr på 500 kr. For Basiskursus, Columna, er prisen dog den samme for alle faggrupper, idet dette kursus er et introduktionskursus.

Der indbetales depositum på 1.000 kr. hvilket sikrer plads på kurserne. Ved skriftlig framelding senest 2 måneder før kursusstart tilbagebetales halvdelen af depositumbeløbet.

Kursussekretær: Birthe Skov, Comwell-Kolding, Skovbrynet 1, 6000 Kolding. Tlf. 76 34 11 00.

Tilmelding: Skriftlig til kursussekretæren. Optagelse finder sted i den rækkefølge, tilmeldingerne modtages.

Anvend venligst tilmeldingsblanketterne i bladet, (fotokopi eller e-mail).
Kursusarrangør: DSMM's uddannelsesudvalg.

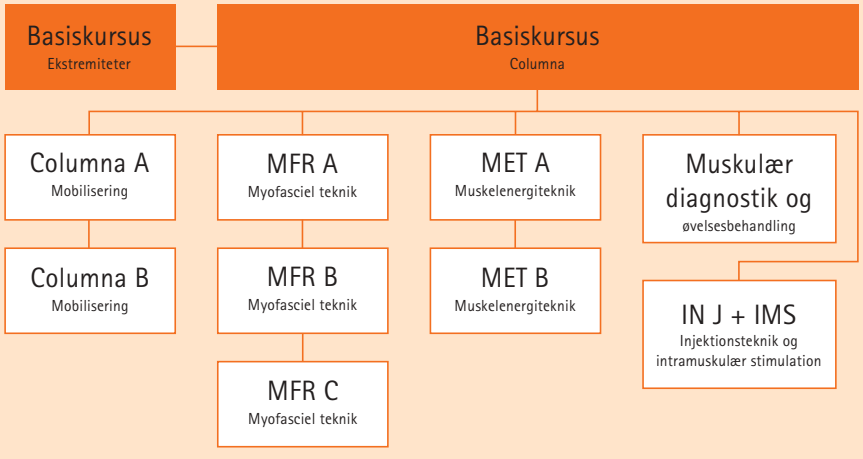
DSMM's lærerstab:
Professor, dr.med. Henning Bliddal, 2000 Frederiksberg
Overlæge Johannes Fossgreen, 8270 Højbjerg
Speciallæge Allan Gravesen, 4220 Korsør
Speciallæge Torben Halberg, 2760 Måløv
Speciallæge Steen Hecksher-Sørensen, 8700 Horsens
Overlæge Palle Holck, 8000 Århus C
Speciallæge Niels Jensen, 2760 Måløv
Speciallæge Jørgen Korsgaard, 3200 Helsinge
Speciallæge Lene Krøyer, 2800 Lyngby
Speciallæge Palle Lauridsen, 5800 Nyborg
Speciallæge Gerd Lyng, 3770 Allinge
Speciallæge Jes Lætgaard, 8700 Horsens
Speciallæge Jette Parm, 4400 Kalundborg
Overlæge Glen Gorm Rasmussen, 9000 Aalborg
Overlæge, dr.med. Lars Remvig, København
Speciallæge Berit Schiøttz-Christensen, 8000 Århus
Speciallæge Pierre Schydlowsky, 3500 Værløse
Speciallæge André Soos, 6100 Haderslev
Speciallæge Lisbeth Wemmelund, 8270 Højbjerg
Speciallæge Peter Silbye, 4600 Køge
Speciallæge Lars Faldborg, 8300 Odder
Speciallæge Finn Johannsen, 2820 Gentofte

Associerede lærere:
Professor, dr.med. Kristian Stengaard-Petersen
Overlæge, dr.med. Bente Danneskiold-Samsøe

DSMM's uddannelsesudvalg:
Niels Jensen, formand
Palle Lauridsen, sekretær
Henning Bliddal, Steen Hecksher-Sørensen,
Lisbeth Wemmelund

Tilmeldingsblanket
kan rekvireres hos kursussekretær
Birthe Skov, Comwell Kolding
Skovbrynet 1, 6000 Kolding
Tlf. 76 34 11 00

Eller via internetadressen www.dsmm.org



DSMM Kursuskalender – 2003-2004

Kursus:	*Tidspunkt: (start 1. dag kl. 9.00, slut sidste dag kl. 16.00)*	*Kursuspris (se nedenfor):*	
		Medlemmer	*Ikke-medlemmer*
☐ Kursus i Strain-Counterstrain Technique – trin 2	29.–31. august 2003	kr. 7.500,-	kr. 8.000,-
☐ MFR B	26.–28. september 2003	kr. 7.400,-	kr. 7.900,-
☐ Columna B Mob.	26.–28. september 2003	kr. 9.600,-	kr. 10.100,-
☐ Columna A Mob.	24.–27. oktober 2003	kr. 9.400,-	kr. 9.900,-
☐ MET B	21.–24. november 2003	kr. 9.400,-	kr. 9.900,-
☐ Basis Columna	21.–25. november 2003	kr. 8.600,-	kr. 11.600,-
☐ Muskulær diagnostik og øvelsesbehandling	9.–16. januar 2004 Club La Santa, Lanzarote	kr. 13.400,-	kr. 13.900,-
☐ INJ + IMS, Injektions og IntraMuskulær Stimulationsbehandling (nålekursus) NYT	23.–25. Januar 2004	kr. 7.400,-	kr. 7.900,-
☐ MFR A	30. januar – 1. februar 2004	kr. 7.400,-	kr. 7.900,-
☐ Basis Columna	27. februar – 2. marts 2004	kr. 8.600,-	kr. 11.600,-

Basiskursus, Columna og Basiskursus, ekstremiteter: Prisen er inkl. lærebog og kursusmateriale.
Kursus i muskulær diagnostik og øvelsesbehandling: Prisen er inkl. rejse og ophold med helpension samt rejseforsikring og særligt kursusmateriale.

Prisen for medlemmer er gældende for følgende faggrupper:
- Medlemmer af DSMM
- Medlemmer af Danske Fysioterapeuters Fagforum for Manuel Terapi
- Medlemmer af McKenzie Institut Danmark

Prisen for ikke-medlemmer gælder øvrige faggrupper.

Forskellen mellem de to kursuspriser skal betragtes som et administrationsgebyr for kursister, der ikke er medlemmer af de nævnte faggrupper.

Kalenderen opdateres på www.dsmm.org

TILMELDINGSBLANKET til DSMM-kurser 2003:

Jeg tilmelder mig herved bindende de ovennævnte kurser, som jeg har afkrydset.

Navn: _____

Adresse: _____

Postnr. og by: _____

Telefon: _____

Jeg er medlem af: ☐ DSMM ☐ McK ☐ MT-gr.

Jeg tilhører følgende fraktion: ☐ P.L.O ☐ FAS ☐ FAYL

Depositum indsender jeg inden for 1 uge efter modtagelsen af optagelsesbekræftigelse på kurset/kurserne, og restbeløbet skal være foreningen i hænde senest 6 uger før påbegyndelse af kursus.

Dato: _____ Underskrift: _____

Tilmeldingsblanketten sendes til : Birthe Skov, Comwell Kolding. Skovbrynet 1, 6000 Kolding. Sammen med check på beløbet.

Kongresserkalender

14. Triennial International FIMM Congress,
15.–18. september 2004
Bratislava, Slovakiet
Manual/Musculoskeletal Medicine an Pain: Evidence and New Challenges.

MCKENZIE INSTITUT DANMARK – Kursuskalender 2003

Sted:	*Kursus:*	*Tidspunkt:*
Kolding	Part D	30. september–3. oktober
Kolding	Part C	4.–6. oktober

Kursusrække:
Sidste år introducerede »Institut for Mekanisk Diagnostik og Terapi« en kursusrække fra Part A til Credentialeksamen. Det er muligt igen i år at tilmelde sig rækken med start på Part A i august 2002. Præcise datoer og priser er annonceret i DF fagblad nr. 3, 2002.
Kurser generelt: Yderligere information kan søges på hjemmesiden: www.McKenzie.dk
Eventuelle spørgsmål kan e-mailes til ajs@teliamail. dk

Sekretær og kursusarrangør:
Merethe Fehrend, Bygaden 60
2630 Taastrup
Tlf. 70 22 04 64 kl.18.00-20.00
E-mail: info@mckenzieinst.dk

Anne Juul Sørensen, Duebrødrevej 5
4000 Roskilde
Tlf. 46 36 49 51 kl. 18.00-20.00
E-mail: ajs@teliamail.dk

Kursuskalender – 2003

Sted:	*Kursus:*	*Tidspunkt:*
Kolding	Trin 3 B (mob)	1.–3. juni
Roskilde	MT-eksamen – del I	14.–15. juni
Odense	Neurodynamisk undersøgelse og behandling (NDUB)	28.–29. august
Kolding	Trin 2 A 1. del 2. del	 31. august – 2. september 14.–15. september
Kolding	Eksamensforløb Modul 1 – ajourførende kursus	7.–9. september
Kerteminde	Dynamisk stabilitet og muskelbalance af skulderen	8.–9. september
Roskilde	MT-eksamen – del II	18. september
København	Movement dysfunction – fokus på dynamisk stabilitet og muskelbalance – »concept course«	6.–7. oktober
København	Dynamisk stabilitet og muskelbalance af lumbal columna og truncus	20.–22. oktober
København	Trin 1 B 1. del 2. del	 26.–28. oktober 16.–17. november
Vejen	Trin 1 A 1. del 2. del	 1.–3. november 15.–16. november
København	Kinetic control – return to work and sport	11.–13. november
København	Kursus med Peter O'Sullivan	23.–25. november
Odense	Caserapport kursus	28. - 29. november

Kalenderen opdateres på: www.manuelterapi.dk

Neurodynamisk undersøgelse og behandling – NDUB

Kursusarrangør: Danske Fysioterapeuters Fagforum for Muskuloskeletal Terapi.

Tid: 28.-29. august 2003.

Sted: Odense.

Kursusform: Eksternat.

Deltagere: Fysioterapeuter.

Undervisere: Medlemmer af MT-gruppens undervisningsgruppe.

Kursuspris: 2.400 kr. For medlemmer er prisen 2.300 kr. Heri indgår kursusmateriale og kaffe/te i pauserne.

Tilmelding: Senest den 20. juni 2003 på tilmeldingsblanket fra Fysioterapeuten, samt crosset, udateret check på beløbet til: Inger Skjærbæk, Rønnebær Allé 2, 3000 Helsingør. Beløbet kan sættes ind på MT-gruppens kursuskonto i Nordea, Stengade 45, 3000 Helsingør. Konto 2255-1905637077.

Husk at få dit navn noteret på kontoudtoget ved denne form for indbetaling.

Tilmelding kan foretages over e-mail.

Oplys fulde navn, adresse (inkl. postnr.) og telefonnumre, samt medlemsnr i DF.

Med hensyn til betaling skal beløbet være indsat senest den 27. juni 2003 for at tilmeldingen tages i betragtning.

Dynamisk stabilitet og muskelbalance af skulderen

Forudsætning: »concept course« (intro)

Kurset vil i detaljer gennemgå den sammensatte undersøgelses og behandlings *approach* af bevægedysfunktion i skulderen. Undervisning vil fokusere på genoptræning af stabilitetsdysfunktionen og impingement set ud fra det lokale og globale muskelsystem.

Tid: 8.–9. september 2003.

Sted: Kerteminde Vandrehjem.

Underviser: Fysioterapeut Dip. MT Flemming Enoch.

Kursuspris: 2.800 kr. inkl. let morgenmad og frokost. Overnatning og evt. aftensmad betales separat. Værelsespris: 345 kr. pr. nat. Angiv om du ønsker enkelt/dobbeltværelse eller ingen overnatning. Der kan ved min. 15 bestillinger arrangeres aftensmad, angiv venligst om dette ønskes.

Tilmelding: Spørgsmål og tilmelding til Niels Honoré på: kc@fysiocenter.dk Medlemmer af Muskuloskeletal fagforum har fortrinsret.

Eksamen i muskuloskeletal terapi Del II

For at kunne deltage i del II-eksamen skal den tilmeldte fysioterapeut have bestået Danske fysioterapeuters fagforum for Muskuloskeletal Terapi's del I-eksamen, have gennemført 150 timers klinisk supervision af godkendte supervisorer i Muskuloskeletal Terapi. Fysioterapi eller beslægtede fagområder.

Endvidere skal tilmeldte fysioterapeut have deltaget i fagforum for Muskuloskeletal Terapi's kurser på trin III, Mobilisering I og II samt klinisk supervision (trin 3C).

Det godkendes endvidere, hvis tilsvarende viden og færdigheder er tilegnet af anden vej.

Retningslinier for fysioterapeuter med udenlandske uddannelser og kurser

Mål og niveau for kurser taget uden for Danmark må mindst være på højde med mål og niveau for den danske kursusrække og dermed IFOMT's krav. Der skal foreligge dokumentation for deltagelse i udenlandske kurser og uddannelser inklusiv mål, indhold og timetal.

Klinisk supervision opnået i udlandet skal dokumenteres og godkendes af fagforum for Muskuloskeletal Terapi.

Kursusrrangør: Danske fysioterapeuters fagforum for Muskuloskeletal Terapi (MT).

Tid: Torsdag den 18. september 2003.

Sted: Fysiocenter Roskilde.

Kursuspris: 500 kr. for medlemmer og 1.000 kr. for ikke medlemmer

Tilmelding: Senest 15. juli 2003 på MT fagforums tilmeldingsblanket, sammen med en crosset check på beløbet til Aase Krog, Lobeliavej 5, 8541 Skødstrup.

NB! Eksamensgebyret går tabt ved afmelding senere end 15. august 2003.

Movement dysfunction – fokus på dynamisk stabilitet og muskelbalance

Forudsætning: »concept course« (intro)

Kurset præsentere en sammensat model inden for *movement dysfunction*. Behovet for at undersøge for bevægefunktion og korrigere bevægedysfunktion i forhold til muskuloskeletal smerte vil bliver gennemgået.

Konceptet identificerer artikulær og myofaciel give og restriktioner i bevægeapparatet og giver anvisninger til genoptræning af dysfunktionen.

Integrationen af specifikke øvelser og muskuloskeletal terapi vil blive gennemgået.

Tid: 6.–7. oktober 2003.

Sted: København, Fysioterapeutskolen.

Underviser: Fysioterapeut Dip. MT Flemming Enoch.

Kursuspris: 2.800 kr. inkl. let morgenmad og frokost.

Tilmelding: Spørgsmål og tilmelding til Niels Honoré på: kc@fysiocenter.dk Medlemmer af Muskuloskeletal fagforum har fortrinsret.

Dynamisk stabilitet og muskelbalance af lumbal columna og truncus

Forudsætning: »concept course« (intro)

Kurset vil i detaljer gennemgå den sammensatte undersøgelses og behandlings »approach« af bevægedysfunktion i lumbal columna og truncus.

Undervisning vil fokusere på genoptræning af stabilitetsdysfunktionen af det lokale og globale muskelsystem.

Tid: 20.–22. oktober 2003.

Sted: København, Fysioterapeutskolen.

Underviser: Fysioterapeut Dip. MT Flemming Enoch.

Kursuspris: 3.800 kr. inkl. let morgenmad og frokost.

Tilmelding: Spørgsmål og tilmelding til Niels Honoré på: kc@fysiocenter.dk Medlemmer af Muskuloskeletal fagforum har fortrinsret.

Diagnostik og mobilisering af columna L, pelvis og underekstremiteter – Trin 2, kursus A

Tid: 1. del: 31. august-2. september 2003.
2. del: 14.-15. september 2003.

Sted: Cromwell, Skovbrynet 1, 6000 Kolding.
Kursusform: Eksternat.

Deltagere: Fysioterapeuter, der har gennemført Trin 1, kursus A og B.

Undervisere: Medlemmer af MT-gruppens undervisningsgruppe.

Kursuspris: 5.300 kr. + 3.000 kr. til lokaleleje inkl. måltider. Der er mulighed for overnatning på Scanticon Comwell. Hvis dette ønskes angives det på tilmeldingsblanketten. Beløbet for internat er 5.050 kr.

Tilmelding: Senest 4. juli på tilmeldingsblanket fra Fysioterapeuten, samt crosset, udateret check på 8.300 til: Inger Skjærbæk, Rønnebær Allé 2, 3000 Helsingør.

Beløbet kan sættes ind på MT-gruppens kursuskonto i Nordea, Stengade 45, 3000 Helsingør. Konto 2255-1905637077.

Husk at få dit navn noteret på kontoudtoget ved denne form for indbetaling.

Tilmelding kan foretages over e-mail: ingerskj@post10.tele.dk – angiv navn, adresse, telefonnumre, samt dit medlemsnr. i DF. Med hensyn til betalingen skal beløbet være indsat senest den 4. juli 2003 for at tilmeldingen tages i betragtning.

8th IFOMT Congress (International Federation of Manipulative Therapy)

Dates: 21-26 March 2004.

Venue: International Convention Centre, Cape Town, South Africa.

Details: This promises to be one of the most exciting events in the history of physiotherapy in South Africa and you are encouraged to start your planning now.

Academic: The theme for the conference is “Balancing the Outcome of Manual Therapy”. The programme will range from research based to clinical outcomes papers. Several speakers of international standing have indicated

their willingness to participate. The programme will include sessions on Pain, Outcome Based Research, Community and Industrial Considerations, Musculo-Skeletal Spinal and Peripheral Dysfunctions.

Social: This promises to be an exciting programme and will include a banquet, wine tasting, and a theme evening at a typical South African venue.

Accomodation: to suit all budgets will be available.

Cape Town: We are very proud of our superb Convention Centre and our beautiful surroundings and know that you will enjoy every aspect of your visit. *Richard Busch, Travel Editor, National Geographic Traveler* agrees with us and writes as follows: "By any standard, the Cape Town region of South Africa is one of the most beautiful and compelling places to visit on the planet. Here, in addition to a city with fascinating historical sites, excellent museums, vibrant markets and a handsomely restored waterfront, I encountered mountain wilderness, rugged coastlines, sandy beaches, lush gardens, beautiful wine estates, superior hotels and some of the warmest, most welcoming people I've ever met".

Website: Our website will be continually updated as further information becomes available – please keep watching: www.uct.ac.za/depgc/pgc/

Enquiries: If you would like further information, please send an expression of interest to:
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Caserapport kursus

Sted: Odense.

Deltagere: Fysioterapeuter, der har gennemført Trin 1 og Trin 2 A + B eller kurser efter den gamle struktur.

Tid: 28.–29. november 2003.

Undervisere: Medlemmer af Dansk Selskab For Forskning.

Kursuspris: 6.000 kr., lokaleleje 500 kr.
Beløbet dækker 2 dages kursus, 1 vejledningsdag, vejledningstimer og rettelse af den færdige case-rapport.

Kursusform: Eksternat.

Tilmelding: Senest den 22. august 2003 på tilmeldingsblanket fra Fysioterapeuten, samt crosset, udateret check på 6.500 kr til: Inger Skjærbæk, Rønnebær Allé 2, 3000 Helsingør.

Beløbet kan sættes ind på MT-gruppens kursuskonto i Nordea, Stengade 45, 3000 Helsingør.
Kontonr. 2255-1905637077.

Husk at få dit navn noteret på kontoudtoget ved denne form for indbetaling.

Tilmelding kan foretages over e-mail: ingerskj@post10.tele.dk – angiv navn, adresse og telefonnumre, samt medlemsnr. i DF.

Med hensyn til betaling skal beløbet være indsat senest den 22. august 2003 for at tilmeldingen tages i betragtning.

Forskning

DSMM har nedsat et videnskabeligt udvalg. Hvis du har forskningstanker og ønsker råd og vejledning, kan du henvende dig til: Forskningsudvalgets formand, overlæge dr.med. Lars Remvig, Klinik for Medicinsk Ortopædi og Rehabilitering, H:S Rigshospitalet, 2100 København Ø.

Der gøres opmærksom på, at Scientific Committee i FIMM har udarbejdet to forskningsprotokoller, der kan hentes på DSMM's hjemmeside: www.dsmm.org under videnskab.

Det drejer sig om reproducibility and validity studies of diagnostic procedures in Manual/ Musculoskeletal Medicine og efficacy-Trials of Therapeutic Procedures in Manual/Musculoskeletal Medicine.

DSMM's lærergruppe har fredag den 2. maj 2003 afholdt møde om den nye kursusstruktur. Det er i forbindelse med tidligere møde blevet besluttet at sammenlægge basiskurset der handler om ekstremiteterne med basiskurset der handler om columna. På forårets møde blev der nedsat arbejdsgrupper der i løbet af de nærmeste måneder vil beskæftige sig med at få hele kursusstrukturen til at fremstå mere overskuelig og enkel. Det nye er, at vi opdeler basiskurset i to kurser. Det første kursus omhandler nedre kvadrant som et hele, dvs. lumbalcolumna, bækken, hofte, knæ, ankel og fodens led. Det andet kursus omhandler øvre kvadrant, dvs. thoracal-og cervicalcolumna med costae, skulder, albue, hånd- og fingerled. Som noget nyt planlægger vi, på opfordring fra kursister gennem årene, faste repetitionskurser der er datolagt i forbindelse med de aktuelle kurser. Den nye kursusstruktur forventes klar i løbet af 2004 (Gerd Lyng).

Læsetips

Paraspinal muscles responses during sudden upper limb loading
Leinonen V et al. *Eur J Applied Physiol* 2002;88:42-9.

Dette studie viste, at de paraspinale muskler aktiveres hurtigere ved en »ventet« belastning sammenlignet med »uventet« belastning af OE målt med overflade-EMG hos raske personer. Studiet viste også, at en visuel forventning reducerer graden af de paraspinale musklers respons ved en pludselig belastning af OE. /cc

Activation of paraspinal and abdominal muscles during maually assisted and nonassisted therapeutic exercise
Arokoski JP et al. *Am J Phys Med Rehabilitation* 2002;81(5):326–35.

Dette studiet af samme finske forsker gruppe viste, at EMG-aktiviteten er mindre i de paraspinale og abdominale muskler ved manuel terapeutiske (MT)-øvelser sammenlignet med ikke-manuel terapeutiske (IMT)-øvelser også målt med overflade-EMG. Dermed synes ikke-MT at være mere effektiv i at aktivere de paraspinale muskler i lumbalcol., men forfatterne påpeger, at IMT kan skabe højere kompressionskræfter i lumbal col., hvilket kan forværre lændesmerter i den initielle fase af et progressivt øvelsesprogram designet til lændesmerter. /cc

MT og Kiropraktik giver kortere sygefravær i Norge
En ny af rapport viser at manuel terapeuter og kiropraktorer reducerer både sygedagpenge udbetalingerne og sygefravær knyttet til muskelskeletsygdomme. Gå ind på:
http://www.fysioterapeuten.no/artikler/dokumenter/arkiv.html
Gå derefter ind på 02/2003 som er en PDF-fil af bladet. Artikel står på side 6 med svar på kritik fra Den norske lægeforening.

Comparing the satisfaction of low back pain patients randomized to receive medical or chiropractic care results from the UCLA low back pain study
Hertz-Miller RP et al. *Am J Public Health* 2002;92(1):1628-33.

Men en separat analyse ved 4-ugers-målingen viste en forskel til fordel for kiropratisk behandling for hvad angår tilfredshed. Det ser ud til at kiropraktorer var bedre til at give råd og information omkring lænderygsmerter end læger, hvilket medførte større tilfredshed. /cc

A randomized trial of medical care with or without physical therapy and chiropractic with or without physical modalities for patients with low back pain: six month follow-up outcomes from the UCLA low back pain study
Hurwitz E et al. *Spine* 2002;27(20):2193-204.

I et nyligt studie fra UCLA, hvor 672 patienter med lænderygsmerter (med/uden ischias-påvirkning) blev randomiseret til enten kiropraktisk behandling (med/ uden fysisk aktivitet) eller standard medicinsk behandling (med/uden fysioterapi) viste ingen forskel imellem de 2 grupper for hvad angår smerte og disability 6 måneders followup. /cc

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