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SCIENTIFIC

PHYSICAL THERAPY

Lumbar Spine Case Study: Patient with Acute Facet Entrapment

by Michaela Hull, PT

Inspection

When first meeting Karen, she could barely get out of the chair and was bent over to the left. She was unable to straighten and walked with a limp on the right and very slowly. She was noted to be in marked pain.

History

The patient is a 32 year old female who was doing laundry at home on 7-13-98 and when she tried to straighten up, she was stopped by severe pain in the low back. Her chief complaint is right sided low back pain and right groin and lateral thigh aching. She is unable to stand up straight. Her pain is aggravated by walking or standing. It is relieved by supine lying. She is able to sleep but her pain gets worse as the day goes on. She has two young children which she is unable to pick up and she is severely limited with all her household activities. She is a homemaker as her main activity. She has no other medical history or previous back problems. She saw the MD on 7-16, who diagnosed her with a severe lumbar strain. She was sent to physical therapy and prescribed muscle relaxants and anti-inflammatories, which she had not begun yet.

Posture

In standing, she is shifted to the left with severe lumbar left side bending and rotation to the right and flexed forward. She has no compensation in the thoracic spine so she is significantly

(Continued on Page Eleven)

Inside this Issue:

The Swedish SBU Report on Back and Neck Pain **Page Two**

Lumbar Case Study ***by Michaela Hull, Page One***

Rauschning Anatomy Slide Series ***Page Seven***

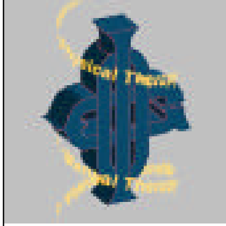
The Swedish SBU Report on Back and Neck Pain

An Evidence Based Review
A Reprint
Conclusion

In the previous issue, we published part one of the report from The Swedish Council on Technology Assessment in Health Care. Originally published in Sweden in 2000, it has recently been translated in English. The original report contains 21 chapters, 2000 references and covers 800 pages. What follows is the second and concluding part of the SBU report on neck and back pain.

Evidence for Treatment of Neck Pain [From SBU's Summary and Conclusions]

	Acute	**Chronic**
Surgery:		
herniated disc	Moderate evidence against	No evidence
fusion, other	No evidence	No evidence
Acupuncture	No evidence against	Strong evidence
Traction	Limited evidence against	Moderate evidence against
Neck support	Limited evidence against	Limited evidence against
Steroid injections	No evidence	Limited evidence
Infrared light	Limited evidence	No evidence
Electromagnetic therapy	Limited evidence	No evidence
TENS	Limited evidence	No evidence
Cold spray & stretching	Limited evidence	No evidence
Patient education	Limited evidence	No evidence
Manual therapy- alone	Limited evidence	No evidence
Drugs, muscle relaxants	Limited evidence	Limited evidence
Laser therapy	Limited evidence	Limited evidence
Manual therapy program	Moderate evidence for	
Physical exercise	Moderate evidence for	Moderate evidence



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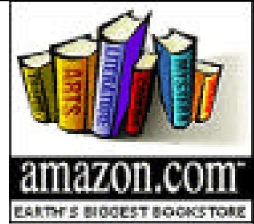

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Appendix 1

Treatment Methods
- An overview of the Results

Level A *Strong evidence* - findings concur in several, randomized controlled trials of high quality.

Level B *Moderate evidence* - findings concur in one randomized controlled trail of high quality and one of more randomized controlled trials of low quality, or findings concur in several studies of low quality.

Level C *Limited evidence* - based on one randomized controlled trial (of high quality or low quality) or contradictory findings in several studies.

Level D *No evidence* -no randomized controlled trials or other types of studies of satisfactory scientific quality.

Conservative Treatment Methods for Low Back Pain

Medication

Strong scientific evidence shows that muscle relaxants, (e.g., benzodiazepines) and anti-inflammatory drugs (NSAIDs) relieve pain in patients with acute and subacute low back problems i.e., problems which have existed up to three weeks or up to 12 weeks (A). However, anti-inflammatory drugs can have serious side effects, particularly in elderly people, and muscle relaxants can cause tiredness and dependency, even after short-term use. Furthermore, there is moderate scientific evidence that paracetamol is effective in relieving acute low back pain (B).

Limited scientific evidence suggests that these drugs are effective in treating chronic low back pain (C). For example, only one study was found that compared the effects of muscle relaxants with the effects of placebo (i.e., no active treatment), but no such studies address analgesics and NSAIDs in people with chronic low back problems.

There are no studies on the effects of anti-depressants in treating acute low back problems (D). However, moderate evidence suggests that these drugs do not have any effect on pain and mobility in patients with chronic low back disorders (B).

Studies show that only limited evidence supports the treatment effects of colchicine (medication for gout) and cortisone in tablet form (system steroids) on acute low back pain (C). Serious side effects have been reported for colchicine, but for system steroids such side effects accompany only long-term use.

Injections

Several different types of injections are used at times to treat both acute and chronic back problems. The injections reviewed were epidural steroid injections, i.e., injections in the spinal cord canal, injections in trigger points and ligaments, and injections in facet joints.

Limited evidence suggests that epidural steroid injections are more effective than placebo for acute and chronic low back problems involving nerve root pain (C). There are no studies addressing the effects of these injections on acute low back problems without nerve root pain (D). However, moderate evidence suggests that these injections do not have any effects on chronic low back pain without root symptoms (B).

There is no evidence on the effects of injections in trigger points, ligaments, or facet joints (D).

Back School

There is limited evidence on the effects of back school on chronic and acute low back problems (C).

Transcutaneous Electrical Nerve Stimulation

There is limited evidence on the effects of TENS on acute and chronic low back problems (C).

Traction

Limited evidence suggests that traction is effective in treating acute low back problems (C). However, strong evidence shows that it is not effective in treating chronic low back problems (A).

Acupuncture

There is no evidence on the effects of acupuncture in treating acute low back pain (D). However, limited evidence suggests that acupuncture is effective in treating chronic low back pain (C).

Physical Treatment Methods

There is no evidence on the effects of cold, heat, short-wave diathermy, massage, or ultrasound in treating acute low back problems (D).

Low Back Corsets and Other Supportive Devices

There is no evidence on the effects of different types of supportive devices in treating acute low back problems (D), and limited evidence regarding their effects on chronic low back problems (C).

Back Exercises/Back Training

Strong evidence shows that back training is effective treatment for chronic low back pain (A). There is also strong evidence that most types of specific back exercises, e.g., bending, traction, aerobic training, strength training, and stretching are not more effective than other interventions in treating acute low back pain (A).

Manual Therapy (Manipulation and Mobilization)

Strong evidence shows that manipulation provides short-term pain relief for chronic low back problems (A) and moderate evidence that it has corresponding effects on acute low back pain (B). There is also moderate evidence that manipulation provides better short-term relief from chronic low back pain compared to routine care from a general practitioner, bed rest, analgesics, or massage (B). Limited evidence suggests that manipulation is more effective than physiotherapy or drugs in relieving acute low back pain (C). The long-term

effects of manipulation are supported only by limited evidence (C). There is a small, but serious, risk for neurological complications from manipulation therapy in patients with progressive neurological deficit.

Behavioral Therapy

There is limited evidence that behavioral therapy is effective in treating acute low back pain (C), but moderate evidence concerning its effects on chronic low back pain (B).

Multidisciplinary Treatment

Strong evidence shows that multidisciplinary treatment is effective in pain relief and functional improvement for patients with long-term and severe chronic low back pain (A).

Biofeedback

Moderate evidence suggests that EMG-based biofeedback is not effective in treating chronic low back problems (B).

Health Resorts

Strong evidence shows that intensive treatment at a health resort reduces short-term pain in elderly patients with chronic low back problems (A).

Bed-Rest

Strong evidence shows that bed-rest is not an effective way to treat acute low back pain (A). The previous perception that 1 to 2 days of bed-rest is effective in treating uncomplicated, acute low back pain has been rejected in scientific studies. Extended bed-rest may cause complications such as joint stiffness, muscle atrophy, osteoporosis, pressure sores, and thromboembolism.

Continued Activity

Strong scientific evidence shows that a gradual reactivation of patients suffering from subacute low back pain, in combination with treatment of pain behavior, helps reduce chronic functional problems and sick leave from work (A).

Conservative Treatment Methods for Neck Pain

Laser Treatment

There is limited evidence on the effects of laser treatment for acute and chronic neck pain (C).

Infrared Light

There is only limited evidence that infrared light has any effect at all on acute neck pain (C).

Electromagnetic Therapy

There is only limited evidence supporting the effectiveness of electromagnetic therapy in treating acute neck pain (C).

Transcutaneous Electrical Nerve Stimulation (TENS)

There is only limited evidence on the effects of TENS in treating acute neck pain (C).

Steroid Injections

Limited evidence suggests that steroid injections are not effective in treating neck pain (C).

Acupuncture

There is no evidence on the effects of acupuncture in treating acute neck pain (D). However, strong evidence shows that acupuncture is not effective treatment for chronic neck pain (A)

Traction

Limited evidence suggests that traction is not effective in treating acute neck pain (C) and moderate evidence suggests that it is not effective in chronic neck pain (B).

Cooling Spray and Stretching

Only one controlled study on patients with acute neck pain addressed the effects of cooling spray combined with passive stretching- a common treatment method in sports medicine. The study is of low scientific quality and showed no differences in outcome between active treatment and placebo (C).

Neck Support

Limited evidence suggests that a neck collar is not effective in treating acute

or chronic neck pain (C).

Manual Therapy

There is only limited evidence on the effects of separate manual therapy for acute neck pain (C), but moderate evidence on its effects when manual therapy is applied as one of several methods in a treatment program for acute neck problems (B). Regarding chronic neck pain, strong evidence shows that manipulation is not more effective than physiotherapy methods (A), and moderate evidence suggests that manipulation is not effective treatment for chronic neck pain (B).

Other Types of Physiotherapy (Massage, Body Movements, and Instruction)

Strong evidence shows that these physiotherapy methods are not more effective in treating chronic neck pain than are alternative forms of treatment, e.g., group exercises, manual therapy, and routine care from a general practitioner (A).

Patient Education

Limited evidence suggests that various types of instruction help reduce acute neck pain (C).

Behavioral Therapy

Limited evidence suggests that behavioral therapy is effective in treating chronic neck pain (C).

Medication

There is limited evidence on the effects of pain-relieving drugs in treating acute neck pain (C), and limited evidence that muscle relaxants are effective in treating chronic neck pain (C).

Physical Training

Moderate evidence suggests that active training is more effective than passive methods, e.g., massage, heat therapy, and stretching, in treating acute neck pain (B).

Surgical Methods

Strong, indirect evidence shows that surgical resection of herniated discs in patients with several weeks of pronounced, lumbar root pain is effective (more effective than chemonucleolysis which in turn is more effective than placebo; A) However, moderate evidence suggests that corresponding surgery is not effective in treating neck problems (B). There is no evidence concerning the effects of fusion surgery in treating chronic pain in the low back or neck (D).

Psychological Treatment Methods

Strong evidence shows that cognitive behavioral therapy (DBT) reduces problems in patients with chronic back pain (A). The effects mainly involve psychological and physiological functions, pain, and medication use. Limited evidence suggests that CBT influences the patient's return to work (C). There is no evidence on the effects of CBT in treating acute back or neck problems (D).

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The Problem of Back Pain-Conference Report (1990)
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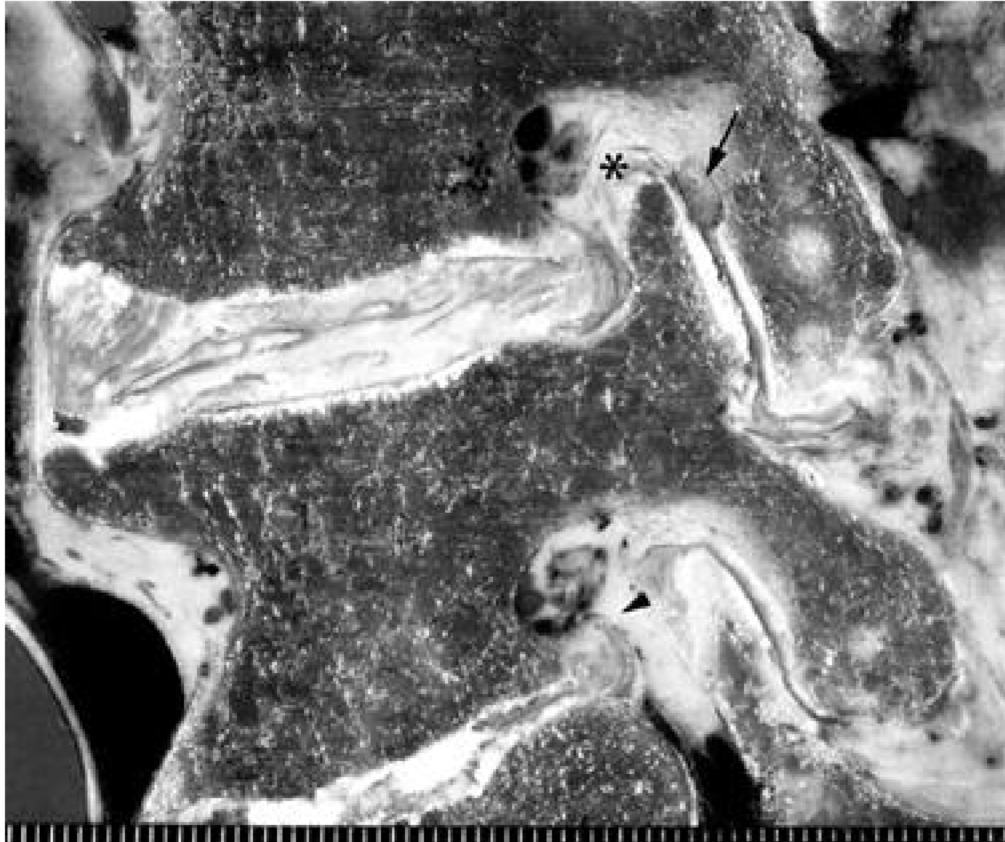

Degenerated lumbar spine of a 70 year-old man with a history of long-standing low back pain. Anteriorly at L4 a segmental artery comes into view, at L5 the left iliac artery and vein (black) lie close to the spine. The L4-L5 disc is severely degenerated and shows loose fragments, complete destruction of the cartilaginous endplates, vacuoles and calcification and anteriorly projecting osteophytes (spondylosis ridges). The posterior annulus occupies the lower half of the foramen, the upper (subpedicular) foramen portion is encroached on by redundant ligamentum flavum. The L4-L5 facet joint is subluxed due to loss of disc height and a meniscoid synovial fold is caught in the upper joint space (arrow). At L5-S1 the cartilaginous endplates have partially fused, the outermost annulus projects posteriorly and lies underneath the L5 root.

With Permission from Wolfgang Rauschning, MD, PhD
Research professor in Clinical Anatomy
Department of Orthopedic Surgery
Academic University Hospital
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(Continued from Page One)

bent over. She also has decreased weight bearing on the right leg.

Active Range of Motion

Flexion—limited and describes a pulling sensation in the low back

Extension—limited and severely painful

Right Side bending—unable to get to neutral and severely painful

Left Side bending—limited with right leg pain

Right rotation—limited but pain free

Left rotation—limited with severe pain

Passive Range of Motion

All were limited but again pain was reproduced with extension, right side bending and left rotation. Combined motions were not performed due to extreme pain with just cardinal plane movement. No leg pain with passive right rotation was provoked.

Resisted Tests

Unable to test due to pain level.

Palpation

Warm and moist over the right lumbar area. Increased muscle tone of the right greater than left erector spinae, multifidi, quadratus lumborum, right gluteals, tensor fascia lata and piriformis. Tender over and interspinous spaces of L4-5 interspinous spaces of L4-5 L5-S1.

Neurology

Dermatomes and cutaneous sensation testing was negative. Reflexes (patellar, achilles) were equal bilaterally and normal. Unable to test myotomes due to pain with resistance.

Special Tests

Straight leg raise, Braggard, Fabere, sacroiliac anterior and posterior ligament stress tests were all negative. Valsalva, Petren's, were negative. Kemp's sign was positive on the right without much ROM in extension and left rotation for extreme back pain but not nerve depolarization.

Segmental Mobility Testing

Flexion was normal.

Extension revealed a grade 1 at L4-5 (and painful), grade 2 at L3-4 and L5-S1.

Right side bending revealed grade 2 at L4-5 and L3-4 with pain.

Left side bending was normal.

Right rotation revealed a grade 2 and L4-5.

Left rotation revealed grade 1 at L4-5 and grade 2 at L3-4.

Shear testing was negative.

Impression

Even though my examination was not full due to the patient's pain level and tolerance to activities being limited, I feel confident the primary tissue in lesion is arthrogenic. I was not able to rule out muscle/tendon with resistive motions but given her pain being the same both actively and passively, this leads to more of an arthrogenic lesion. Due to the mechanism of injury and the lack of ability to close pack the right facet, she probably has a joint entrapment. She has significant muscle tenderness/pain but this is probably due to the tonic reflexive guarding from the entrapment rather than the primary cause of pain. It also did not appear to be discogenic due to lack of neural signs and negative increased intrathecal pressure tests. Treatment should involve soft tissue mobilization of the above noted muscles that are in guarding followed by joint mobilization at L3-4 and L4-5 that would open the right facets at this level. Also exercises for vascularity of the muscles in guarding and rotation exercises for compression/decompression of the facet cartilage with combined flexion/extension for gliding should be given once the entrapment is relieved.

Initial Treatment

Soft tissue mobilization utilizing cross fiber work both with and without joint motion for the right side multifidi, the quadratus

(Continued on Page Twelve)

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(Continued from Page Eleven)
lumborum, and erector spinae was done. This was followed by right rotation and left side bending mobilizations at L4-5 and L3-4 in left side lying. To be specific to these levels I rotated down to L3 and extended L5-S1 to lock from below. She had no pain with these mobilizations. I did just a trial treatment of three repetitions of each. I then gave her a self mobilizing exercise of lying over a pillow on her left side with her knees bent up and rotating to the right. This would open the right facet joints. I then ended the treatment with interferential stimulation to the right side musculature to try to facilitate some relaxation of the muscles and to decrease pain. Upon leaving, the patient was able to stand almost erect and reported her pain to be 50% better.

Follow-up Treatment

I was supposed to have seen the patient two days later; however, she called to tell me that she was 99% better and able to fully bend and rotate and stand up straight. She reported the day after the initial treatment she was walking when she felt a sudden burning sensation in her right lumbar spine after twisting and then a relief of symptoms. Because of this sudden relief of pain, I feel my impression of a joint entrapment was correct and that she probably had the entrapment fully released when she twisted giving her the burning sensation followed by relief and full range of motion. If she were to have returned to therapy, I would have made sure she had full return of segmental mobility and had given her more exercises for gliding and compression/decompression of the facet cartilage to assure full synovial movement over the surface and rehydration of the cartilage.

OGI Graduates Sound Off to APTA Commission on Accreditation Regarding entry level DPT

Michael Emery, PT, EdD
Commission on Accreditation in Physical Therapy Education
APTA
1111 North Fairfax Street
Alexandria, Virginia 22314

Dear Chairman Emery,

I am writing in whole-hearted, 100% support of Norm Madsen's position regarding doctoral education. I have been a therapist for 23 years and have taught with the Ola Grimsby Institute in its Master and Doctoral program for the past 12 years. I am also a clinical education supervisor and mentor for therapists within my region.

In my opinion and experience, there is absolutely no way graduates of current clinical doctorate programs are clinicians able to diagnose and treat musculoskeletal problems at a level worthy of a clinical doctorate. There is a significant lack of clinical reasoning skills, primarily based on a lack of qualified supervisory experience. Intensive residency programs are required in other fields yet ours is extremely inadequate. It is a whole other question as to whether these graduates are actually able to consistently and competently assess problems with clear reasoning based on anatomy, neurophysiology, histology, arthrokinematics, and exercise physiology.

As far as a DPT being a point of entry, I for one would not trust a DPT to be able to screen for medical contraindications much less produce an appropriate differential diagnosis.

David Sheer, MOMT, PT

Dear Chairman Emery,

I am a student in the Ola Grimsby Institute DPT residency program. I have completed all my course work and am currently finishing my dissertation. While the past two and half years of part-time residency have been challenging, I am very grateful for the rigorous and excellent education that I have received. I finally feel like I am becoming a competent physical therapist who can evaluate and treat orthopedic pathologies.

Recently I heard that the APTA may begin granting approval for entry level DPT programs that do not require a residency component. I believe that our profession would be making a great mistake if this practice is adopted. We need to be training and mentoring competent therapists who will be able to live up the title of "Doctor." Adding a few more weeks to existing PT programs without including a rigorous residency requirement will not produce the caliber of therapists that will bring respect and credibility to our profession.

I hope the APTA will require all doctorate programs to have a residency component.

Julie Danielson, PT

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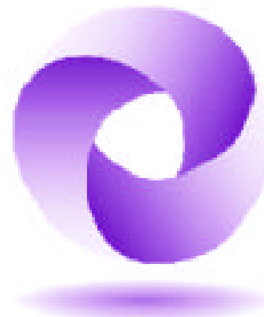

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This course is a prerequisite for MT-2, MT-3 and MT-4.

MT-2 Modern Manual Therapy of the Lower Quarter
Seattle, WA .... Jun 8-10
Participants must complete MT-1, MT-5 or MT-6 before entering this course.

MT-3 Modern Manual Therapy of the Upper Quarter
Chicago, IL .... May 4-6
Participants must complete MT-1, MT-5 or MT-6 before entering this course.

MT-4A S.T.E.P. Extremities
(Scientific, Therapeutic Exercise Progressions)
Indianapolis,IN (5Day) .... April 25-29
Atlanta, GA .... June 8-10
Norfolk, NJ (5 Day) .... June 13-17
Raleigh, NC .... July 13-15
San Diego, CA .... July 20-22
Participants must complete MT-1, PTA-1, MT-5 or MT-6.

MT-4B S.T.E.P. Spine
(Scientific, Therapeutic Exercise Progressions)
Memphis, TN .... April 6-8

MT-5 Modern Manual Therapy of the Extremities
Seattle, WA .... April 11-15
Atlanta, GA .... May 9-11
Los Angeles, CA .... September 12-16
Chicago, IL .... October 3-7
Raleigh, NC .... October 10-14
This course is a prerequisite for MT-2, MT-3 and MT-4.

MT-6 Modern Manual Therapy of the Spine
Grand Rapids, MI .... June 6-10
Miami, FL .... June 6-10
Pittsburg, PA .... July 18-22
San Francisco, CA .... September 12-16
Chicago, IL .... September 20-24
Nashiville, TN .... November 7-11
St. Louis, MI .... November 7-11

MT-9 Clinical Problem Solving
Call the Ola Grimsby office for details

MT-10 Nutrition and Its Role in Orthopedics & Sports
Chicago, IL .... April 7
Miami, FL .... June 9

MT-11 The Shoulder in Orthopedics and Sports
Chicago, IL .... June 23-24

MT-12 Knee Rehabilitation in Orthopedics & Sports
Chicago, IL .... October 13-14

MT-13 Soft Tissue Course
New Orleans, LA .... **April 28-29**
Pittsburg, PA .... June 9-10
Palm Springs, CA .... September 22-23

PTA-1 Basic Sciences in Manual Therapy for PTA's
Los Angeles, CA .... June 3-4
This course is a prerequisite for PTA-2

PTA-2 Clinical Manual Therapy for PTA's
Seattle, WA ...... August 5-6
San Francisco, CA September 16-17
Chicago, IL .. September 23-24
Kansas City, MO .. October 7-8
Portland, OR .... October 7-8
Las Vegas, NV . October 14-15
Dallas, TX ..... November 4-5
Los Angeles, CA November 4-5

A Scientific Publication in Newsletter Format

SCIENTIFIC PHYSICAL THERAPY

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- Nutrition
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- Clinical Research

Published research articles from around the world will be reviewed - as will unpublished **Norwegian Manual Therapy** research.

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