Academy of PHYSICAL MEDICINE

Broadcast Summary

Open Forum with James Booth

26th February 2015

The iO Spinal Fellowship

- Daunting, but rewarding
- An opportunity to develop the profession (feedback from surgical team is very positive)
- Fellowship details:
    - A one-year, paid position at Queen's Medical Centre, Nottingham
    - Funded by the iO
    - Two days per week:
        - one with James in clinic with a high volume of chronic patients, many with yellow flags, who may already have had:
            - Spinal intervention
            - Failed physiotherapy, osteopathy or chiropractic
            - Pain medication
        - The other observing/learning from colleagues within the hospital (surgical, sports medicine, pain management)
- Selection procedure
    - Open to any osteopath registered with the GOsC
    - Applications go to iO
    - Shortlisted, based on covering letter and CV
    - Those shortlisted attend open day at QMC
    - Final cut of 3 created
    - Successful applicant selected by interview
- Characteristics of the successful applicant:
    - Prepared to learn
    - Communication across the professions is a crucial skill
    - Commitment – it's a year of intensive learning

Work at the QMC Spinal Unit

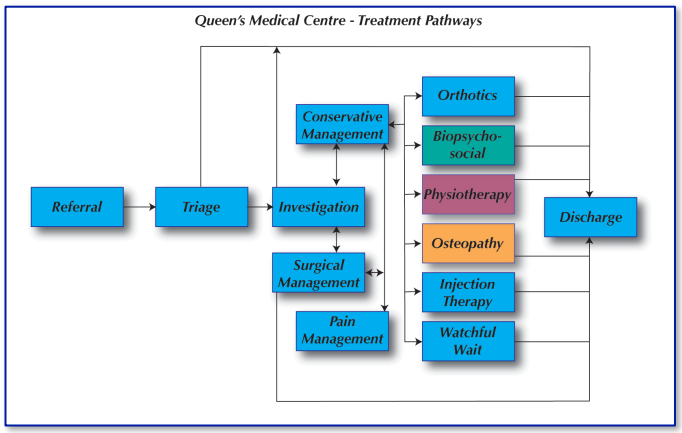
- The relationship with physiotherapists:
    - Very good: no evidence of professional jealousy
    - QMC is one of Europe's foremost spinal centres, and the quality of the physiotherapists reflects this
    - Physios often do much less manual therapy than osteos, because:
        - They work with a broad range of conditions, where this would not necessarily be appropriate
        - In the community (ie NHS referrals to physio) they may be contractually bound to only give exercises.

        - In some cases, exercise prescription is the scope of their practice
- The osteopaths:
    - unlike many community osteopaths, who often deal almost exclusively with acute pain issues, those at QMC will become used to working with chronic and complex issues
    - waiting times currently up to 6 months – demand rising due to success of service
    - generally seeing patients for 10 – 12 appointments. Currently follow-up appointments not available, although there's a growing awareness that some require this (as with other ongoing conditions, such as diabetes), but the system is overwhelmed.
    - cost-effectiveness of the service to the NHS has not yet been assessed (plenty of data, but very complex, not yet statistically powerful), but patients treated:
        - Have lower dependence on further intervention
        - 43% come off all their related medications
        - Many return to normal daily living
    - Effect on James's private practice difficult to assess as he was very busy in any case. Local GPs now are more willing to make contact however, seeking opinions on referral routes, patient management. More referrals from consultants.
- Breaking down specialisations:
    - many simple procedures now carried out by lesser trained practitioners (ie spinal injections – previously a consultant role)
    - some discussion recently (discussion only!) that even complex procedures (such as orthopaedic surgery) could be conducted by doctors with less extensive training
    - at QMC, increasingly, triage is being done by extended scope physios. Early indications are that this is better: 90% patients do not need surgery and do not therefore need to see a spinal consultant.
    - Extended Scope Physios:
        - Experienced physios
        - Undergo a training competency package concentrating on spinal pathology:
            - Probably a 6-month course
            - Identifying red flags
            - Patient assessment, especially neurological
            - Recognition of spinal pathologies

- Breaking down barriers:
    - Trainee consultants very receptive to an osteopathic alternative. Provides an avenue for the many patients they see who are not suitable for surgery.
    - Equally, the physio and the biopsychosocial options are well received.
    - Annual presentation to trainee consultants at QMC covers:
        - Evidence for manual therapy
        - Patient types:
            - Patho-anatomical conditions (eg disc bulges, stenosis, myelopathy) tend to need surgery, injection therapy or pain management
            - Biopsychosocial (significant psychological component, centrally sensitised, neuropathic)
            - Movement disorders
            - Many have an overlap – identifying the primary problem is important

Treatment pathway:

- Referrals come from GPs
- Triage by ESP or Spinal Surgeon



- Investigation radiologically if indicated, but note:
  - Roughly 30% of 20-year-olds, will have a radiologically diagnosable spinal pathology
  - 90% of 80-year-olds will have an identifiable pathology[1]
- Surgical intervention not necessarily the first option even when images correlate with symptoms. Likely to use nerve block to confirm
- Orthotics relates principally to spinal orthoses (eg collars and thoraco-lumbar spinal braces), not foot orthotics. Foot orthotics can be part of the solution.
- Biopsychosocial:
  - Team comprises physiotherapists, specialist nurses and psychologists.
  - Strong evidence for this methodology in certain chronic pain. Manual therapy is unhelpful in these cases.
  - Desensitisation process needed – education about pain science – before recommencing manual therapy.
  - In extreme cases, where pathology is severe, programme is about acceptance that the condition will not improve.
  - Patients may become very dependent on BPS treatments.
- Osteopathy and Physiotherapy: the triage team have a good understanding of what each profession handles well. If one therapy hasn't worked, it's likely that the other one will be tried. Patient beliefs also must be taken into account
- Injection therapy can be diagnostic or remedial. Commonly the facet joints or sacroiliac joints will be injected under fluoroscopic guidance. Nerve root blocks are used to prove a diagnosis. SIJ blocks can buy a window of opportunity for manual therapy. Drugs used are steroids (triamcinolone), long-acting anaesthetic (bupivacaine) and anti-convulsants (gabapentin, pregabalin).
- Watchful wait: needs to be explained well to patient, or it can sound very woolly. Can be expressed in a positive light. Can also be reassuring for patients that they will be seen again in a few weeks/months to ensure satisfactory progress/no deterioration.
- Pain Management: One of the fastest growing disciplines in the NHS currently.
  - QMC has a specialist team of consultant anaesthetists.
  - Designed for patients whose pain will not respond to other treatment
  - Chronic pain is increasing, some of which is iatrogenic, some because of greater longevity
  - Partly the problem may be due to greater patient expectations of pain management.

Some Other Issues

- Tagging and Smudging: an important concept within central sensitisation (where the nervous system is "ramped up" and unable to ignore what would ordinarily be unremarkable pain signals).
  - Smudging describes the effect where a minor stimulus triggers a response around the body
  - Tagging is the effect whereby certain circumstances are subconsciously associated with pain, hence feeling relief when going on holiday, for example (although the patient will probably identify this as weather related!)

[1] Brinjikji et al, American Journal of Neuroradiology, 2014 Nov 27

- Scoliosis: defined as mild, moderate or severe, depending on radiological appearance. Clinically, there are a large number of potential classifications. Mild scoliosis often not important. But in a younger patient it may be unstable and should be corrected early.
- Treating an exaggerated thoracic kyphosis (example given was a 30-year-old woman, could be symptomatic, but has concerns about her posture in the long term)
    - Gentle kyphosis, should be reasonably mobile in a 30-year-old, is likely to respond well to exercise and manual therapy
    - If more significant, particularly rigid, or associated with pain then vertebral collapse due to lytic lesion or osteoporotic lesion must be considered and may require referral
    - Similarly, Scheurmann's disease in the young should be considered and referred
- Prescribing drugs:
    - Possibly some osteos would resist this option as unosteopathic
    - There are occasions where there may be little alternative
    - Range of appropriate drugs would be quite small
    - Ability to prescribe would shorten the time to treatment, by avoiding the need to see a GP
    - An osteo might be better informed on best drugs for back pain (very high incidence of comorbidity with long term use of opioids, which are in any case ineffective for chronic pain)
- Often we are over-optimistic in our expectations of outcomes, especially regarding posture.
- What can we do to save out hands?
    - Difficult to find ways to spend less time treating
    - Research
    - Teaching
- Research
    - Changes in the approach to evidence-based medicine: recent BMJ article relating to the evidence-based movement being in crisis[2]
    - There have been abuses of research (intentional and otherwise)
    - Financial/commercial pressures are very strong
    - Understanding research is difficult and a better understanding is required across the board
- Useful Resource: *Explain Pain*, by David Butler and Lorimer Mosely (and associated publications)

[2] *BMJ* 2014;348:g3725