Presentation Handout

Understanding the Subspecialty of Orthopaedic Manual Physical Therapy and Clinical Practice Guidelines: A Case Based Approach

Paul Lonnemann PT, DPT, OCS, FAAOMPT
Nathan Nevin PT, DPT, OCS, FAAOMPT

Learning Objectives

- Interpret the Orthopaedic Manual Therapy Framework for Management of Lower Back pain with a Patient case example
- Identify the most recent Clinical Practice Guidelines for Treatment of Low back pain
- Examine red flags, precautions, evaluation components and treatment considerations
- Discuss Key concepts of the OMPT evaluation and examination framework
- Integrate findings into an OMPT framework
- Discuss select evaluation and manual therapy interventions

What is the Definition & Conceptual Model of OMPT?

What is OMPT?

International Federation of Manipulative Physical Therapists (IFOMPT)

Definition

Orthopaedic Manual Physical Therapy is a specialised area of physiotherapy/physical therapy for the management of neuro-musculoskeletal conditions, based on clinical reasoning, using highly specific treatment approaches including manual therapy techniques and therapeutic exercises. Orthopaedic Manual Physical Therapy also encompasses, and is driven by, the available scientific and clinical evidence and the biopsychosocial framework of each individual patient.

What is OMPT?

Systematic and Active Approach

Based on a Patient-Centered Advanced Clinical Reasoning Model

Orthopaedic Manual Physical Therapy is a specialised area of physiotherapy/physical therapy for the management of neuro-musculoskeletal conditions, based on clinical reasoning, using highly specific treatment approaches including manual therapy techniques and therapeutic exercises. Orthopaedic Manual Physical Therapy also encompasses, and is driven by, the available scientific and clinical evidence and the biopsychosocial framework of each individual patient.

Long Term Mindset

Focus on Clinical Judgement

Expertise in Hands-on Examination and Treatment

A Conceptual Model of OMPT

Clinical reasoning

~An ongoing decision-making process used throughout the episode of care

Jensen GM, Shepard KF, Gwyer J, Hack LM. Attribute dimensions that distinguish master and novice physical therapy clinicians in orthopedic settings. Phys Ther. 1992;72:711–722.

Physical Therapy

Systematic Clinical Reasoning in Physical Therapy (SCRIPT): Tool for the Purposeful Practice of Clinical Reasoning in Orthopedic Manual Physical Therapy

Sarah E. Baker, Elizabeth E. Painter, Brandon C. Morgan, Anna L. Kaus, Evan J. Petersen, Christopher S. Allen, Gail D. Deyle, Gail M. Jensen

VOLUME 97, Number 1, January 2017

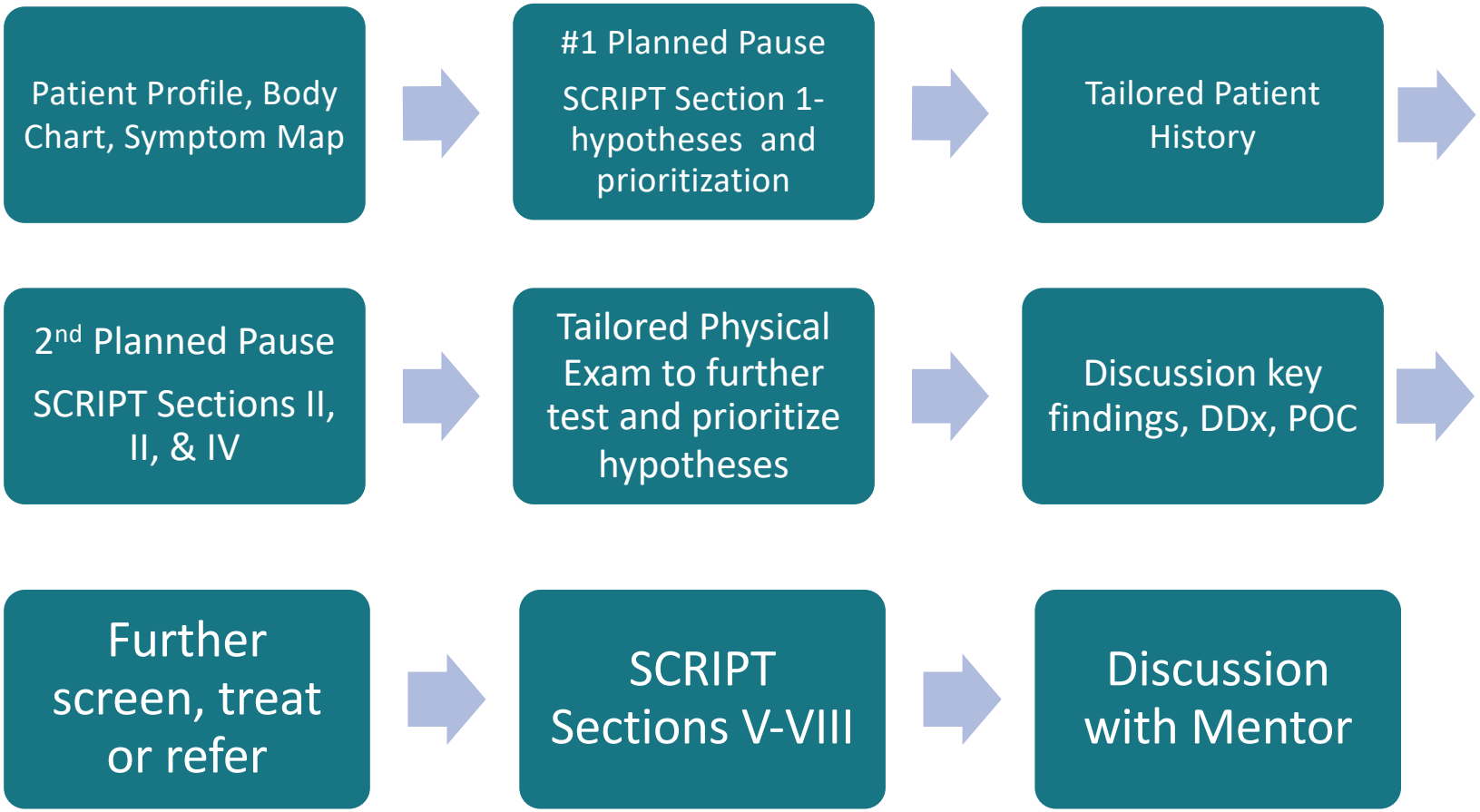
Clinical reasoning

- Analytical & deductive process that requires inductive (narrative) thinking
- Systematic consideration and prioritization of variables and uncertain factors affecting the patient
- Probe deeper with appropriate follow-up questions to understand the patient's story

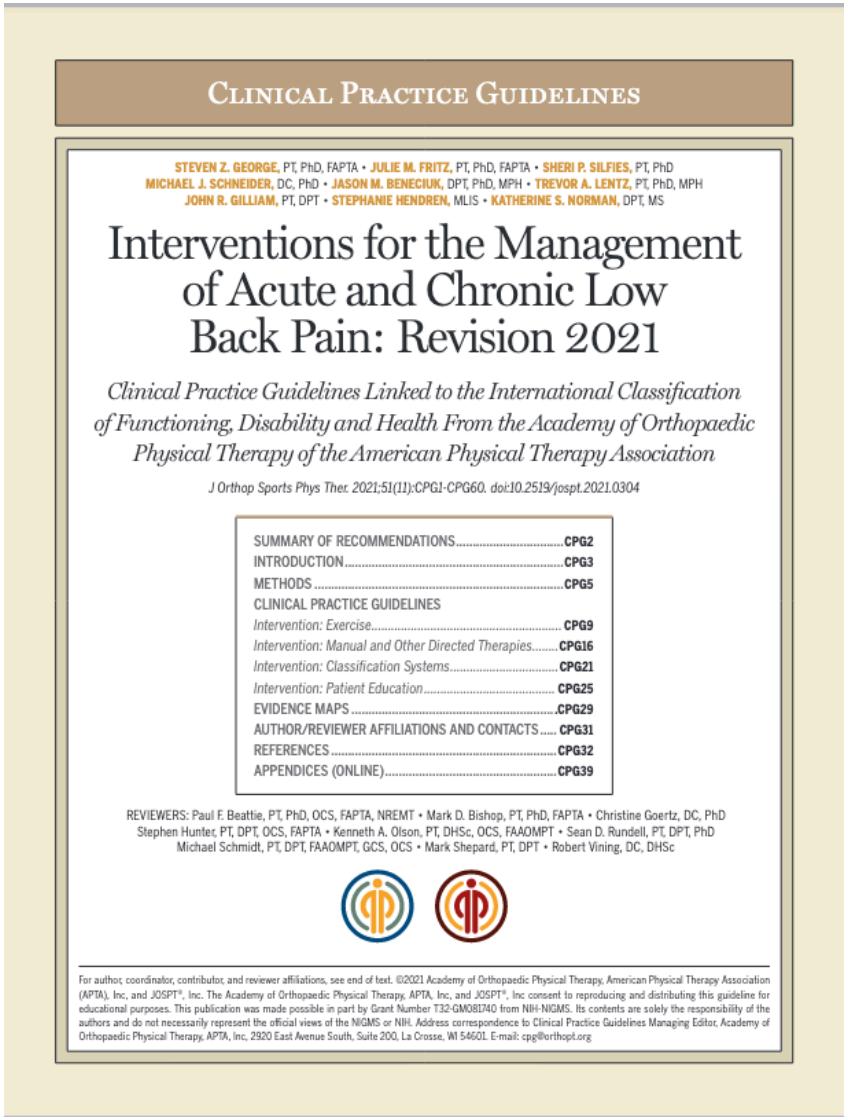
How?

- Within the context of a patient encounter and reflection

SCRIPT PROCESS



https://www.jospt.org/doi/pdf/10.2519/jospt.2021.0507



CLINICAL PRACTICE GUIDELINES

STEVEN Z. GEORGE, PT, PhD, FAPTA • JULIE M. FRITZ, PT, PhD, FAPTA • SHERI P. SILFIES, PT, PhD
MICHAEL J. SCHNEIDER, DC, PhD • JASON M. BENECIUK, DPT, PhD, MPH • TREVOR A. LENTZ, PT, PhD, MPH
JOHN R. GILLIAM, PT, DPT • STEPHANIE HENDREN, MLIS • KATHERINE S. NORMAN, DPT, MS

Interventions for the Management of Acute and Chronic Low Back Pain: Revision 2021

Clinical Practice Guidelines Linked to the International Classification of Functioning, Disability and Health From the Academy of Orthopaedic Physical Therapy of the American Physical Therapy Association

J Orthop Sports Phys Ther. 2021;51(11):CPG1-CPG60. doi:10.2519/jospt.2021.0304

REVIEWERS: Paul F. Beattie, PT, PhD, OCS, FAPTA, NREMT • Mark D. Bishop, PT, PhD, FAPTA • Christine Goertz, DC, PhD
Stephen Hunter, PT, DPT, OCS, FAPTA • Kenneth A. Olson, PT, DHSc, OCS, FAAOMPT • Sean D. Rundell, PT, DPT, PhD
Michael Schmidt, PT, DPT, FAAOMPT, GCS, OCS • Mark Shepard, PT, DPT • Robert Vining, DC, DHSc

For author, coordinator, contributor, and reviewer affiliations, see end of text. ©2021 Academy of Orthopaedic Physical Therapy, American Physical Therapy Association (APTA), Inc, and JOSPT®, Inc. The Academy of Orthopaedic Physical Therapy, APTA, Inc, and JOSPT®, Inc consent to reproducing and distributing this guideline for educational purposes. This publication was made possible in part by Grant Number T32-GM081740 from NIH-NIGMS. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the NIGMS or NIH. Address correspondence to Clinical Practice Guidelines Managing Editor, Academy of Orthopaedic Physical Therapy, APTA, Inc, 2920 East Avenue South, Suite 200, La Crosse, WI 54601. E-mail: cpg@orthopt.org

TABLE 1 Levels of Evidence

I	Evidence obtained from high-quality diagnostic studies, prospective studies, randomized controlled trials, or systematic reviews
II	Evidence obtained from lesser-quality diagnostic studies, prospective studies, systematic reviews, or randomized controlled trials (eg, weaker diagnostic criteria and reference standards, improper randomization, no blinding, less than 80% follow-up)
III	Case-control studies or retrospective studies
IV	Case series
V	Expert opinion

TABLE 2 GRADES OF RECOMMENDATION

Grades of Recommendation		Strength of Evidence	Level of Obligation
A	Strong evidence	A preponderance of level I and/or level II studies support the recommendation. This must include at least 1 level I study	Should
B	Moderate evidence	A single high-quality randomized controlled trial or a preponderance of only level II studies support the recommendation. This included studies with short-term follow-up (eg, 3 months or less) and smaller sample sizes (eg, fewer than 100 participants)	May
C	Weak evidence	A single level II study supports the recommendation	Can
D	Conflicting or no evidence	Level I and/or level II studies disagree with respect to their conclusions or provide no evidence of benefit	Should not

Clinical Guidelines to Address Low Back Pain: Using the Evidence to Guide Physical Therapist Practice

Journal of Orthopaedic & Sports Physical Therapy 2021;51(11):533-534. DOI: 10.2519/jospt.2021.0507

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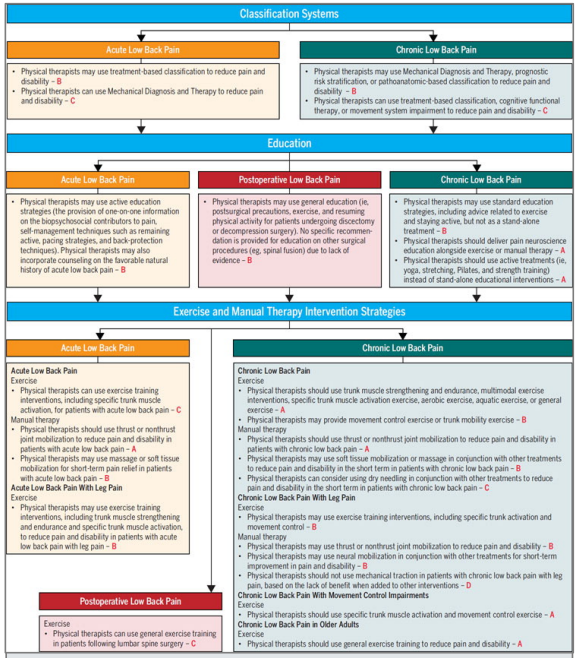
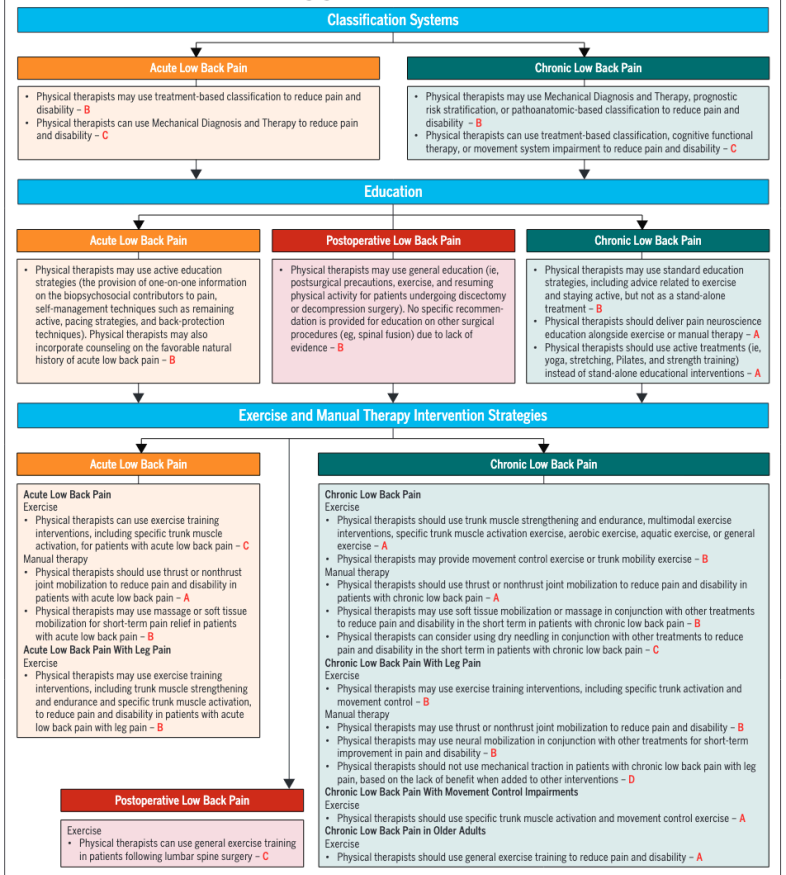


Based on the guidelines, the grades in this flow chart may be translated as follows: A, strong evidence; B, moderate evidence; C, weak evidence; D, conflicting evidence. figure produced for the *JOSPT* by Kate Minick, PT, DPT, OCS, of Intermountain Healthcare, Salt Lake City, UT.

JOSPT PERSPECTIVES FOR PRACTICE

Interventions for Managing Acute and Chronic Low Back Pain: Care Process



Based on the guidelines, the grades in this flow chart may be translated as follows: A, strong evidence; B, moderate evidence; C, weak evidence; D, conflicting evidence. Figure produced for the *JOSPT* by Kate Minick, PT, DPT, OCS, of Intermountain Healthcare, Salt Lake City, UT.

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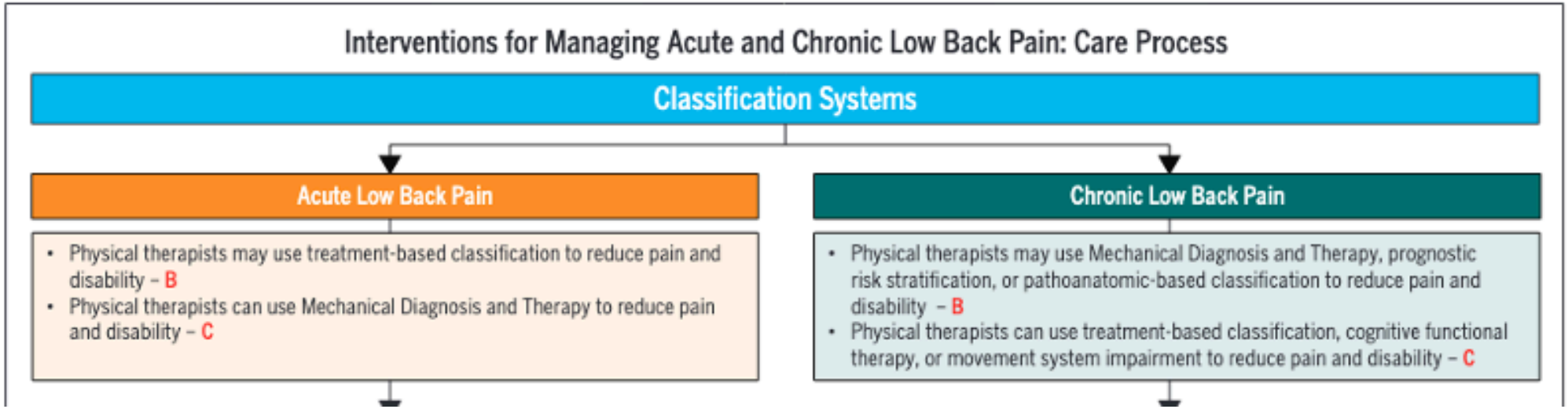
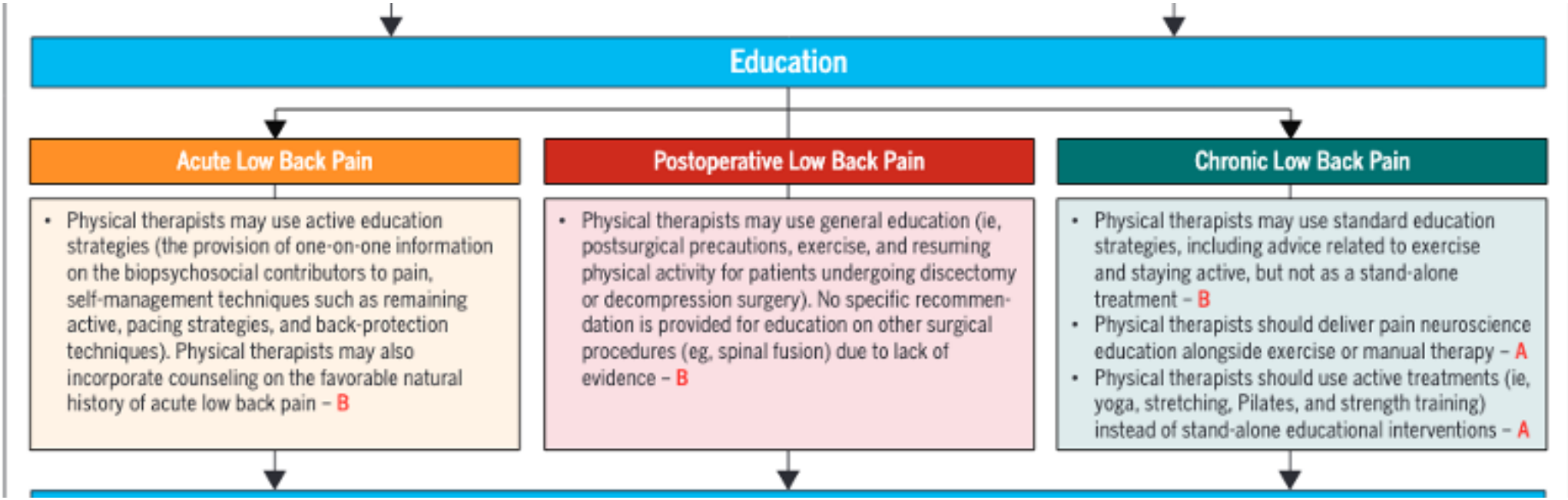
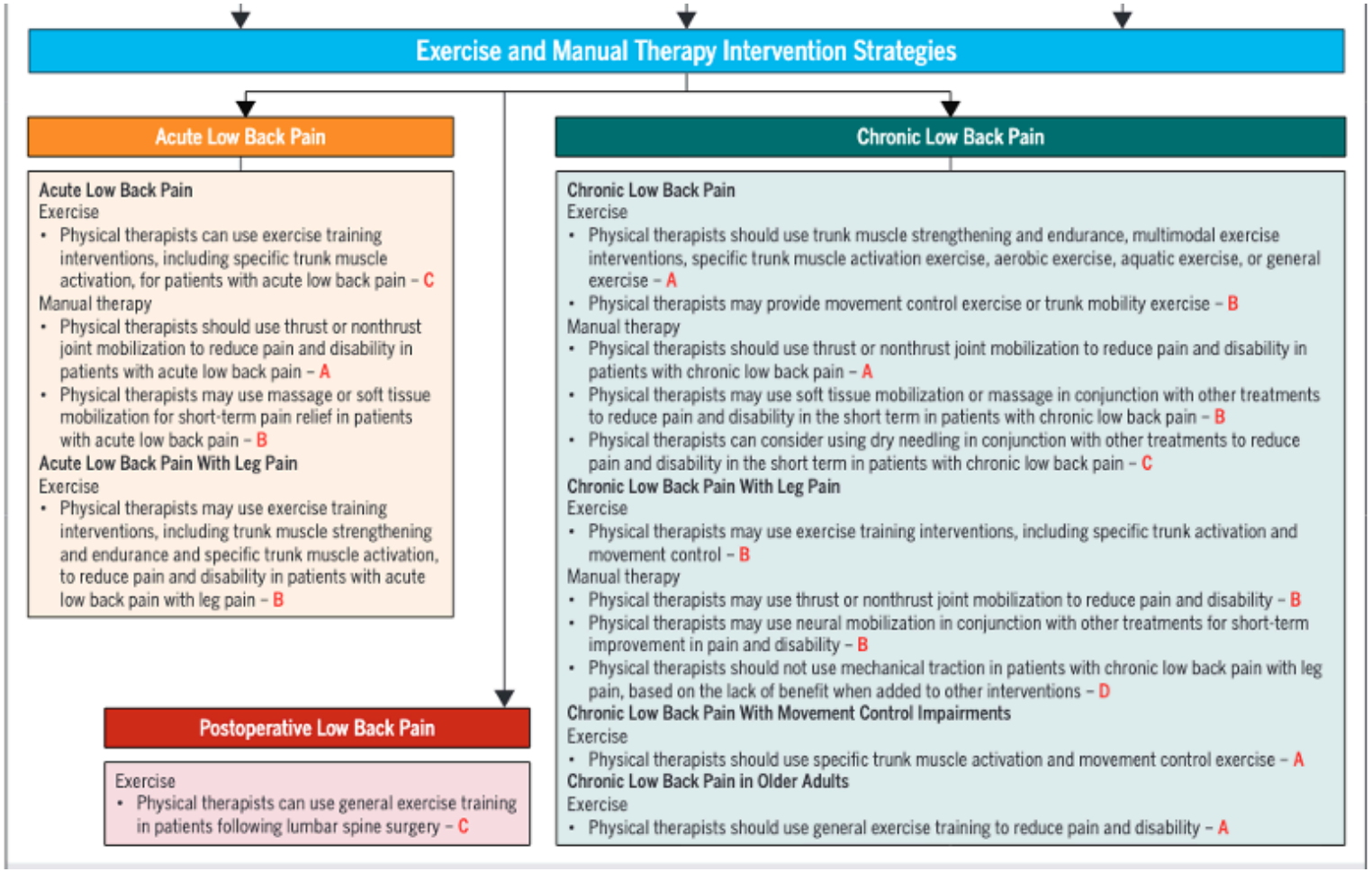
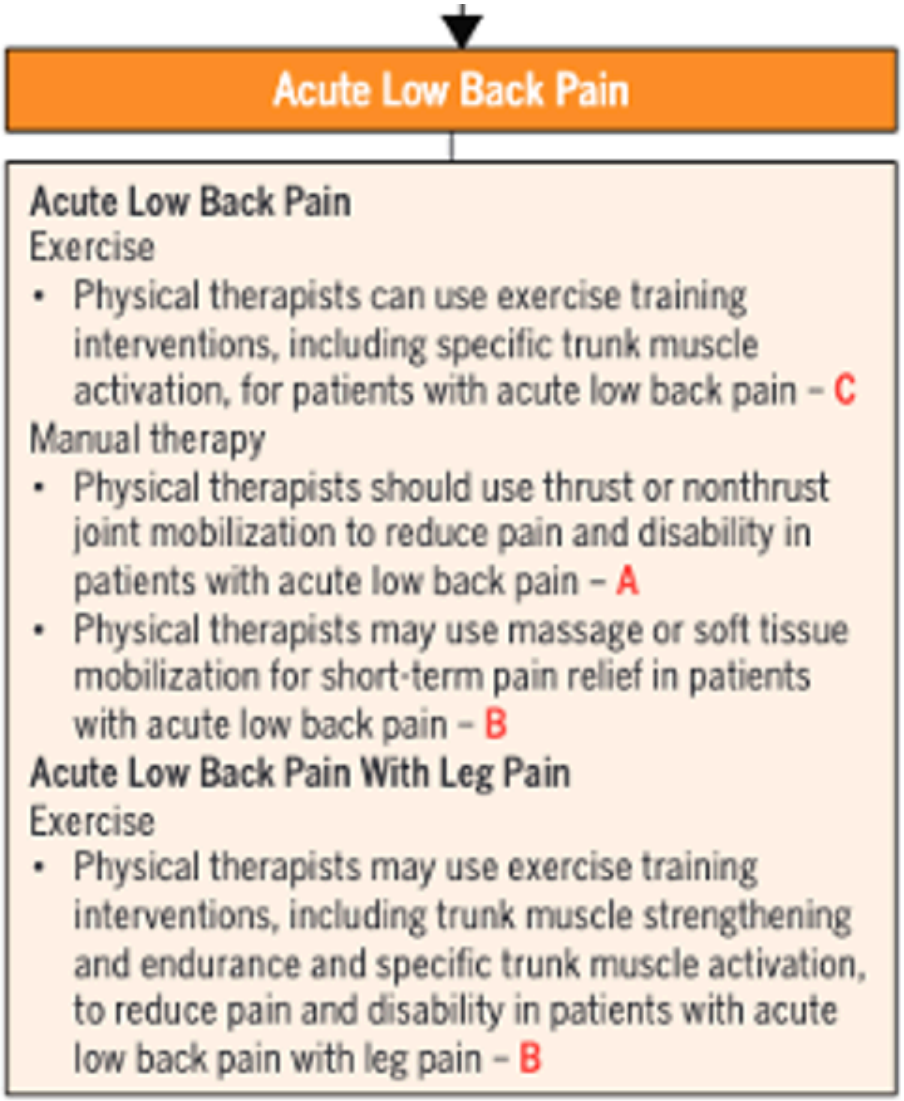
JOSPT PERSPECTIVES FOR PRACTICE




Education
Acute Low Back Pain
• Physical therapists may use active education strategies (the provision of one-on-one information on the biopsychosocial contributors to pain, self-management techniques such as remaining active, pacing strategies, and back-protection techniques). Physical therapists may also incorporate counseling on the favorable natural history of acute low back pain – B
Postoperative Low Back Pain
• Physical therapists may use general education (ie, postsurgical precautions, exercise, and resuming physical activity for patients undergoing discectomy or decompression surgery). No specific recommendation is provided for education on other surgical procedures (eg, spinal fusion) due to lack of evidence – B
Chronic Low Back Pain
• Physical therapists may use standard education strategies, including advice related to exercise and staying active, but not as a stand-alone treatment – B
• Physical therapists should deliver pain neuroscience education alongside exercise or manual therapy – A
• Physical therapists should use active treatments (ie, yoga, stretching, Pilates, and strength training) instead of stand-alone educational interventions – A


Exercise and Manual Therapy Intervention Strategies
Acute Low Back Pain
Acute Low Back Pain
Exercise
• Physical therapists can use exercise training interventions, including specific trunk muscle activation, for patients with acute low back pain – C
Manual therapy
• Physical therapists should use thrust or nonthrust joint mobilization to reduce pain and disability in patients with acute low back pain – A
• Physical therapists may use massage or soft tissue mobilization for short-term pain relief in patients with acute low back pain – B
Acute Low Back Pain With Leg Pain
Exercise
• Physical therapists may use exercise training interventions, including trunk muscle strengthening and endurance and specific trunk muscle activation, to reduce pain and disability in patients with acute low back pain with leg pain – B
Postoperative Low Back Pain
Exercise
• Physical therapists can use general exercise training in patients following lumbar spine surgery – C
Chronic Low Back Pain
Chronic Low Back Pain
Exercise
• Physical therapists should use trunk muscle strengthening and endurance, multimodal exercise interventions, specific trunk muscle activation exercise, aerobic exercise, aquatic exercise, or general exercise – A
• Physical therapists may provide movement control exercise or trunk mobility exercise – B
Manual therapy
• Physical therapists should use thrust or nonthrust joint mobilization to reduce pain and disability in patients with chronic low back pain – A
• Physical therapists may use soft tissue mobilization or massage in conjunction with other treatments to reduce pain and disability in the short term in patients with chronic low back pain – B
• Physical therapists can consider using dry needling in conjunction with other treatments to reduce pain and disability in the short term in patients with chronic low back pain – C
Chronic Low Back Pain With Leg Pain
Exercise
• Physical therapists may use exercise training interventions, including specific trunk activation and movement control – B
Manual therapy
• Physical therapists may use thrust or nonthrust joint mobilization to reduce pain and disability – B
• Physical therapists may use neural mobilization in conjunction with other treatments for short-term improvement in pain and disability – B
• Physical therapists should not use mechanical traction in patients with chronic low back pain with leg pain, based on the lack of benefit when added to other interventions – D
Chronic Low Back Pain With Movement Control Impairments
Exercise
• Physical therapists should use specific trunk muscle activation and movement control exercise – A
Chronic Low Back Pain in Older Adults
Exercise
• Physical therapists should use general exercise training to reduce pain and disability – A


Acute Low Back Pain
Acute Low Back Pain
Exercise
• Physical therapists can use exercise training interventions, including specific trunk muscle activation, for patients with acute low back pain – C
Manual therapy
• Physical therapists should use thrust or nonthrust joint mobilization to reduce pain and disability in patients with acute low back pain – A
• Physical therapists may use massage or soft tissue mobilization for short-term pain relief in patients with acute low back pain – B
Acute Low Back Pain With Leg Pain
Exercise
• Physical therapists may use exercise training interventions, including trunk muscle strengthening and endurance and specific trunk muscle activation, to reduce pain and disability in patients with acute low back pain with leg pain – B

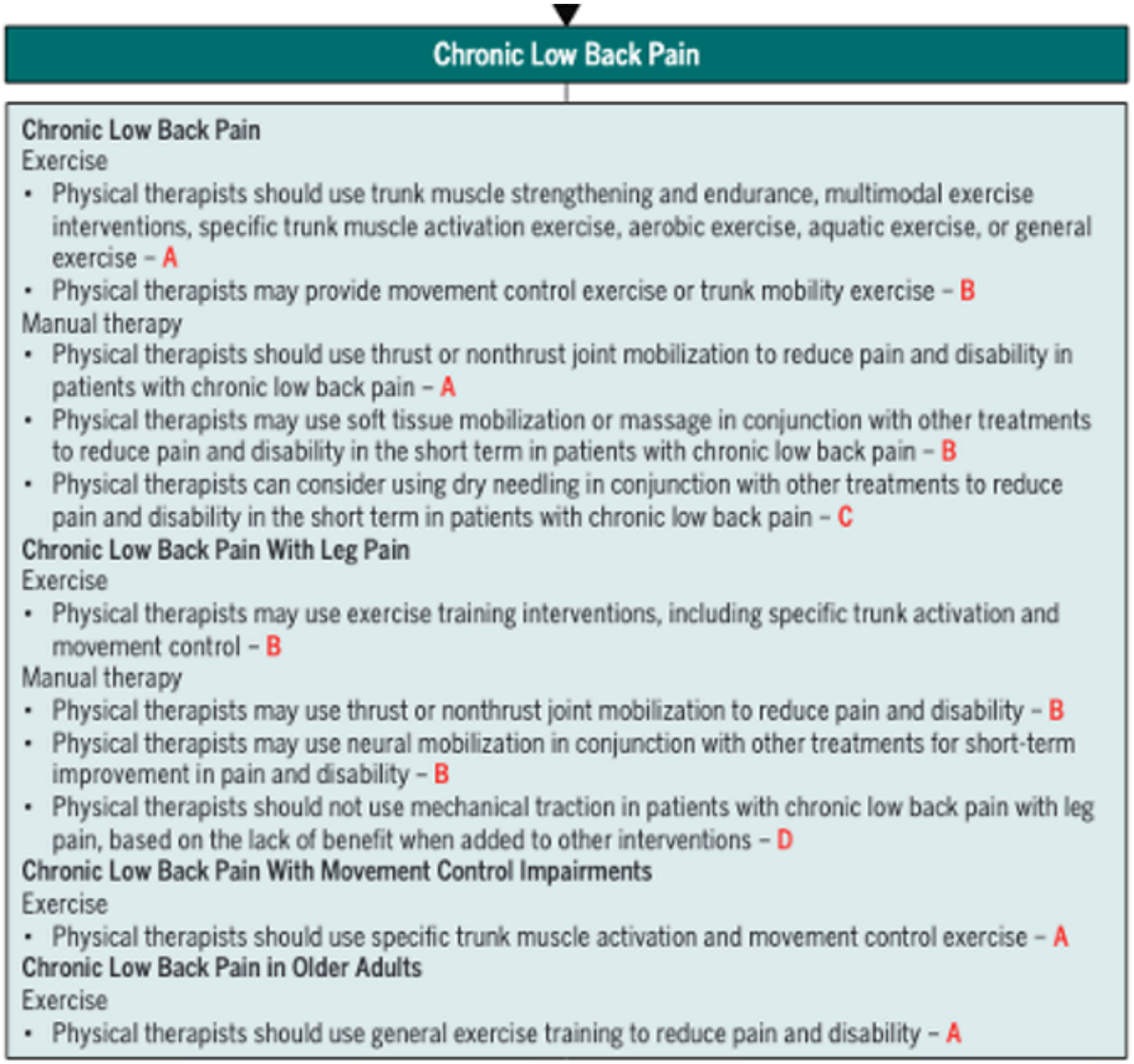

Chronic Low Back Pain
Chronic Low Back Pain
Exercise
• Physical therapists should use trunk muscle strengthening and endurance, multimodal exercise interventions, specific trunk muscle activation exercise, aerobic exercise, aquatic exercise, or general exercise – A
• Physical therapists may provide movement control exercise or trunk mobility exercise – B
Manual therapy
• Physical therapists should use thrust or nonthrust joint mobilization to reduce pain and disability in patients with chronic low back pain – A
• Physical therapists may use soft tissue mobilization or massage in conjunction with other treatments to reduce pain and disability in the short term in patients with chronic low back pain – B
• Physical therapists can consider using dry needling in conjunction with other treatments to reduce pain and disability in the short term in patients with chronic low back pain – C
Chronic Low Back Pain With Leg Pain
Exercise
• Physical therapists may use exercise training interventions, including specific trunk activation and movement control – B
Manual therapy
• Physical therapists may use thrust or nonthrust joint mobilization to reduce pain and disability – B
• Physical therapists may use neural mobilization in conjunction with other treatments for short-term improvement in pain and disability – B
• Physical therapists should not use mechanical traction in patients with chronic low back pain with leg pain, based on the lack of benefit when added to other interventions – D
Chronic Low Back Pain With Movement Control Impairments
Exercise
• Physical therapists should use specific trunk muscle activation and movement control exercise – A
Chronic Low Back Pain in Older Adults
Exercise
• Physical therapists should use general exercise training to reduce pain and disability – A

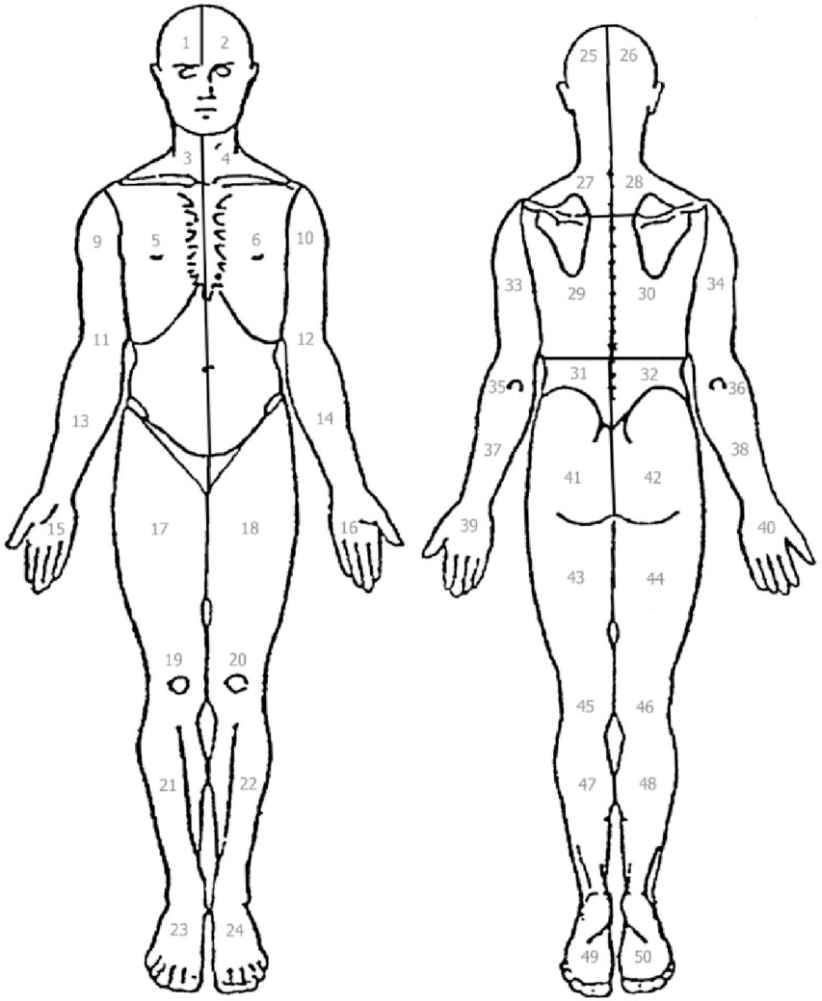
TABLE 4 Operational Definitions for Exercise

Intervention	Operational Definition
Trunk muscle strengthening and endurance exercise	Exercise training prescribed to restore or improve strength, endurance, or power of trunk muscles or muscle groups
Specific trunk muscle activation exercise	Exercise training prescribed to target specific deep trunk muscles (eg, transversus abdominis, multifidus) using cocontraction to alter or restore control or coordination of the lumbopelvic region
Movement control exercise	Exercise training prescribed to alter, restore, or retrain control of functional movements and tasks, with feedback on movement patterns
General exercise	Exercise training prescribed to restore or improve overall strength or endurance of the major muscle groups of the upper/lower extremities and trunk, including exercises for flexibility/mobility and aerobic/conditioning exercises
Trunk mobility exercise	Exercise training prescribed to restore trunk range of motion or to repeatedly move the trunk in a specific direction to achieve a reduction of symptoms
Aerobic exercise	Exercise training prescribed to restore or enhance capacity or efficiency of the cardiovascular system
Multimodal exercise	Exercise training that combines 2 or more of the interventions described above

TABLE 6 Operational Definitions for Classification Systems

Intervention	Operational Definition
Mechanical Diagnosis and Therapy	Classification method based on changes in low back pain (and/or lower extremity) symptoms in response to direction-specific, repeated lumbar spine movements or sustained postures. Findings are used to classify patients into different syndromes (ie, derangement, dysfunction, or postural) that guide the treatment approach
Treatment-based classification	Classification method to guide initial treatment approach (manipulation, stabilization, specific exercise, or traction) based on specific initial assessment findings, including but not limited to patient history, clinical presentation, and physical examination
Movement system impairment	Classification method based on impaired trunk movements and postures associated with low back pain symptoms observed during a standardized examination. Test results are used to classify patients based on observed lumbar movement or alignment impairments (rotation, extension, flexion, rotation with extension, or rotation with flexion), with subgroup assignment guiding the initial treatment approach to match specific signs and symptoms
Cognitive functional therapy	Classification method that uses an integrated behavioral approach for individualizing the management of low back pain Pathoanatomical, physical, psychological, social, lifestyle, and health-related risk factors are assessed, with nonmodifiable barriers and a modifiable target for change identified to guide treatment based on 3 components ("making sense of pain," "exposure with control," and "lifestyle change"). Formerly called O'Sullivan's classification system
Prognostic risk stratification	Classification method that identifies patients at different levels of risk for persistent pain (low, medium, high) using a multidimensional screening tool, with each risk category associated with different treatment pathways. Examples include the STarT Back Tool
Pathoanatomic-based classification	Classification method based on pathoanatomic-based findings from examination that could cause low back pain Subgroups are defined by symptom location and response to examination procedures and used to guide the treatment approach

62 Year-Old Female with Lower back pain and Right Leg Pain of 5 months duration



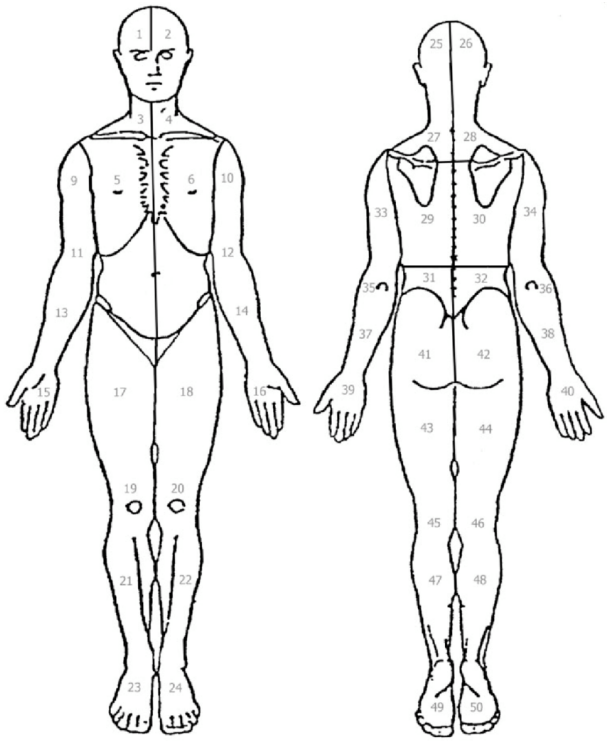
https://www.researchgate.net/figure/The-body-diagram-used-by-FM-patients-to-indicate-local-pain-comprised-of-50-standardized_fig1_7158249/download

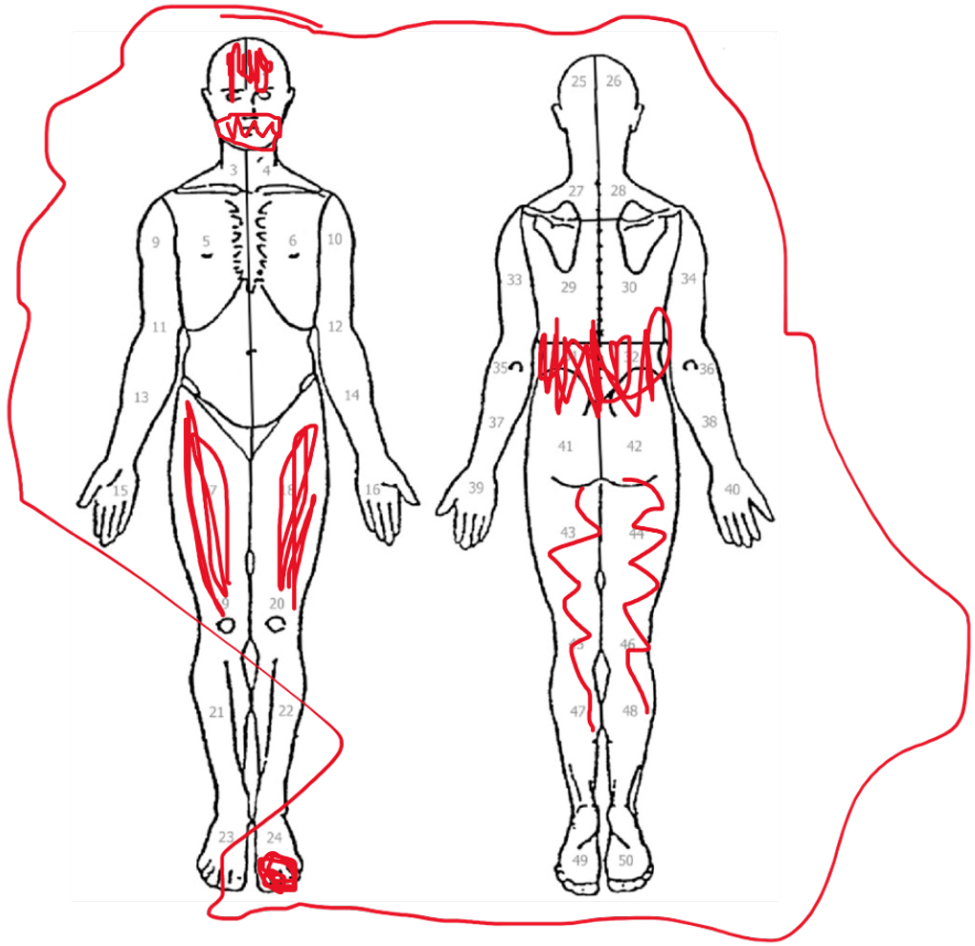
shutterstock.com · 520601062

What stands out to you about this Patient?

- 62 Year-Old Female with Lower back pain and Right Leg Pain of 5 months duration
  - Pathoanatomical model- AGE- what conditions are likely, unlikely?
    - Signs and Symptoms that are RED FLAGS?
    - What Diagnostic Tests might be required related to age?
    - Differential Diagnoses?

What Does Her Pain Diagram Look Like?

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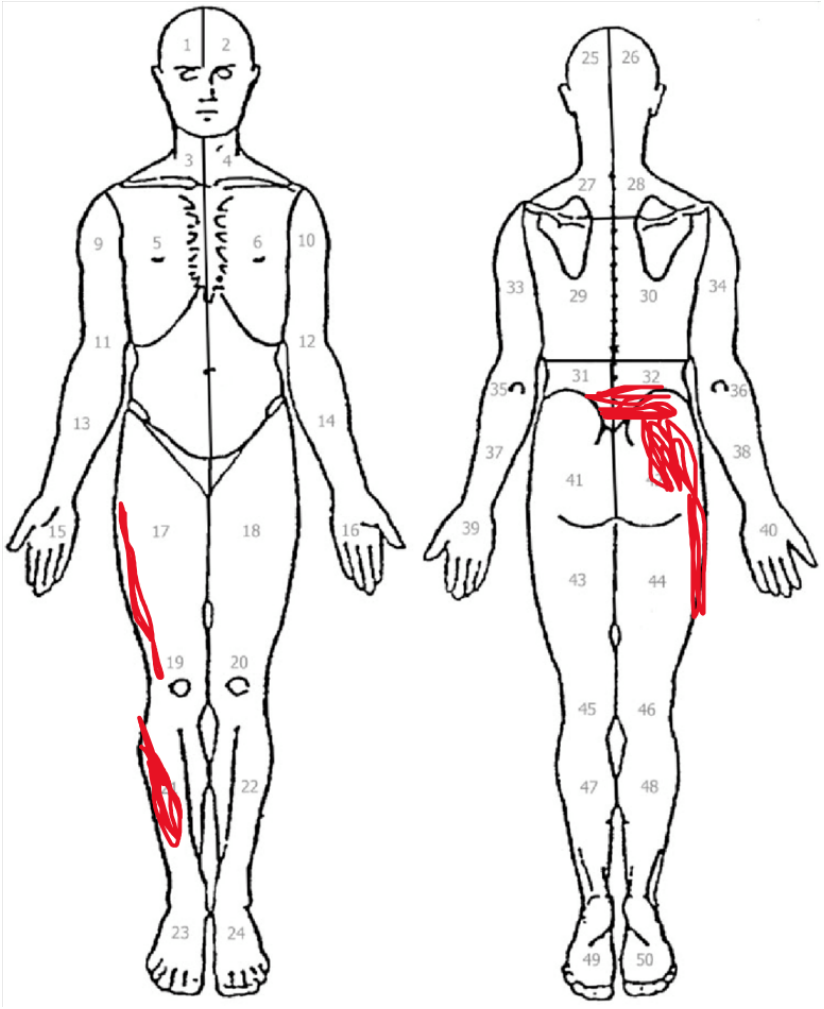
Our Patient's Actual Pain Diagram



Oswestry Disability Index

OSWESTRY LOW BACK DISABILITY QUESTIONNAIRE

Instructions: this questionnaire has been designed to give us information as to how your back pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the ONE box which applies to you at this time. We realize you may consider 2 of the statements in any section may relate to you, but please mark the box which most closely describes your current condition.

1. PAIN INTENSITY
- ☐ I can tolerate the pain I have without having to use pain killers
- ☐ The pain is bad but I manage without taking pain killers
- ☐ Pain killers give complete relief from pain
- ☐ Pain killers give moderate relief from pain
- ☐ Pain killers give very little relief from pain
- ☐ Pain killers have no effect on the pain and I do not use them

2. PERSONAL CARE (e.g. Washing, Dressing)
- ☐ I can look after myself normally without causing extra pain
- ☐ I can look after myself normally but it causes extra pain
- ☐ It is painful to look after myself and I am slow and careful
- ☐ I need some help but manage most of my personal care
- ☐ I need help every day in most aspects of self care
- ☐ I don't get dressed, I was with difficulty and stay in bed

3. LIFTING
- ☐ I can lift heavy weights without extra pain
- ☐ I can lift heavy weights but it gives extra pain
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, i.e. on a table
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
- ☐ I can lift very light weights
- ☐ I cannot lift or carry anything at all

4. WALKING
- ☐ Pain does not prevent me walking any distance
- ☐ Pain prevents me walking more than one mile
- ☐ Pain prevents me walking more than ½ mile
- ☐ Pain prevents me walking more than ¼ mile
- ☐ I can only walk using a stick or crutches
- ☐ I am in bed most of the time and have to crawl to the toilet

5. SITTING
- ☐ I can sit in any chair as long as I like
- ☐ I can only sit in my favorite chair as long as I like
- ☐ Pain prevents me from sitting more than one hour
- ☐ Pain prevents me from sitting more than ½ hour
- ☐ Pain prevents me from sitting more than 10 minutes
- ☐ Pain prevents me from sitting at all

6. STANDING
- ☐ I can stand as long as I want without extra pain
- ☐ I can stand as long as I want but it gives me extra pain
- ☐ Pain prevents me from standing for more than one hour
- ☐ Pain prevents me from standing for more than 30 minutes
- ☐ Pain prevents me from standing for more than 10 minutes
- ☐ Pain prevents me from standing at all

7. SLEEPING
- ☐ Pain does not prevent me from sleeping well
- ☐ I can sleep well only by using medication
- ☐ Even when I take medication, I have less than 6 hrs sleep
- ☐ Even when I take medication, I have less than 4 hrs sleep
- ☐ Even when I take medication, I have less than 2 hrs sleep
- ☐ Pain prevents me from sleeping at all

8. SOCIAL LIFE
- ☐ My social life is normal and gives me no extra pain
- ☐ My social life is normal but increases the degree of pain
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, i.e. dancing, etc.
- ☐ Pain has restricted my social life and I do not go out as often
- ☐ Pain has restricted my social life to my home
- ☐ I have no social life because of pain

9. TRAVELLING
- ☐ I can travel anywhere without extra pain
- ☐ I can travel anywhere but it gives me extra pain
- ☐ Pain is bad, but I manage journeys over 2 hours
- ☐ Pain restricts me to journeys of less than 1 hour
- ☐ Pain restricts me to short necessary journeys under 30 minutes
- ☐ Pain prevents me from traveling except to the doctor or hospital

10. EMPLOYMENT/ HOMEMAKING
- ☐ My normal homemaking/ job activities do not cause pain.
- ☐ My normal homemaking/ job activities increase my pain, but I can still perform all that is required of me.
- ☐ I can perform most of my homemaking/ job duties, but pain prevents me from performing more physically stressful activities (e.g. lifting, vacuuming)
- ☐ Pain prevents me from doing anything but light duties.
- ☐ Pain prevents me from doing even light duties.
- ☐ Pain prevents me from performing any job or homemaking chores.

https://www.aaos.org/globalassets/quality-and-practice-resources/patient-reported-outcome-measures/spine/oswestry-2.pdf

Her Score?

Score	Disability Level
0-20	No to Minimal Disability
21-40	Moderate Disability
41-60 **42**	Severe Disability
61-80	Crippling
81-100	Bed Bound

https://www.aaos.org/globalassets/quality-and-practice-resources/patient-reported-outcome-measures/spine/oswestry-2.pdf

SCRIPT FORMAT

- Second Planned Pause- Collect thoughts then summarize

Motivational Interviewing

Open Ended Questions/Statements

- So, It looks like you have been having some trouble for awhile, What brings you in today?

- Tell me about when this started.
- How has it has changed?

Patient History

- Presents with acute onset after lifting, carrying boxes in garage 5 months ago. Symptoms started in the lower back and to the right side of upper buttock.
- 2 months ago started developing intermittent right lateral leg pain, and tingling in the lateral leg.
- Walking worse, leg pain relieved after sitting

- Patient Goals:
  - Return to Walking 2-3 miles, 3 times per week
  - Decrease Pain
  - Sleep better

What Questions Do You ask Her?
What are their **SINSS?**

- **S**everity- Intensity of Symptoms (Pain level)
- **I**rritability- What makes it Worse, Better, How long it takes to subside?
- **N**ature- IS IT Musculoskeletal? Red Flags/Yellow Flags (Psychosocial)
- **S**tage- Acute <3 weeks, Subacute 3-6 weeks, Chronic >6 weeks
- **S**tability- IS your CONDITION getting Better, Worse, About the Same, Fluctuating?

https://www.physio-pedia.com/Severity,_Irritability,_Nature,_Stage_and_Stability_(SINSS)

Patient Responses- **SINSS**

- **S**everity- 1/10 to 8/10, currently 4/10
  - Mild? Moderate? Severe?

- **I**rritability- Worse with standing, standing after prolonged sitting, better with position changes. Eases with sitting.

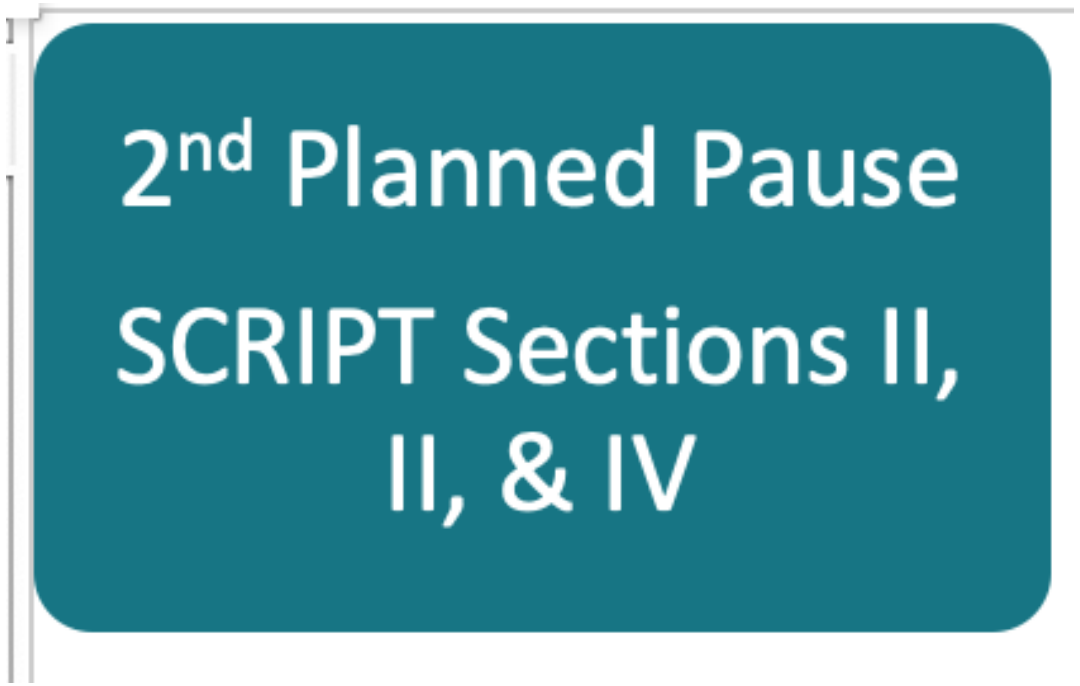
- **N**ature- Bladder leaks with coughing, laughing; No other bowel or bladder control problems.
  - Pain at night with certain positions (stomach sleeping, better for a time sidelying)
  - Oswestry an issue? Other tests/outcome measures recommended?

Patient Responses- **SINNS**

- **S**tage- CHRONIC

- **S**tability- Worse with fluctuating leg symptoms

SCRIPT FORMAT



Signposting

Structures Conversation, Engages Patient

Summarize Findings and what you are thinking, talk about what you plan to do next, education on likely cause of problem and how you plan to help.

- Opportunity to get/give clarity
- Gets patient thinking about condition and solutions
- Collaborative in nature (Therapeutic Alliance)

https://doctorsspeakup.com/content/signposting

How would you Signpost based on your information so far?

Examination

- Inspection
- AROM- Repeated movements? Directional Preference?
- Palpation-
  - Condition- Temperature, Moisture, tissue resistance
  - Position- Deformities?
  - Mobility- Posterior Anterior mobility- central, unilateral, Passive Intervertebral motion testing (PAIVM, PIVM)

Neurological Screening

L1-S2 Myotomes- Normal

L1-S2 Dermatomes- Normal

L3-4, L5, S1 Reflexes- Normal

L1, L2 - Hip Flexion

L2-3 - Hip Adduction

L3 - Knee Extension

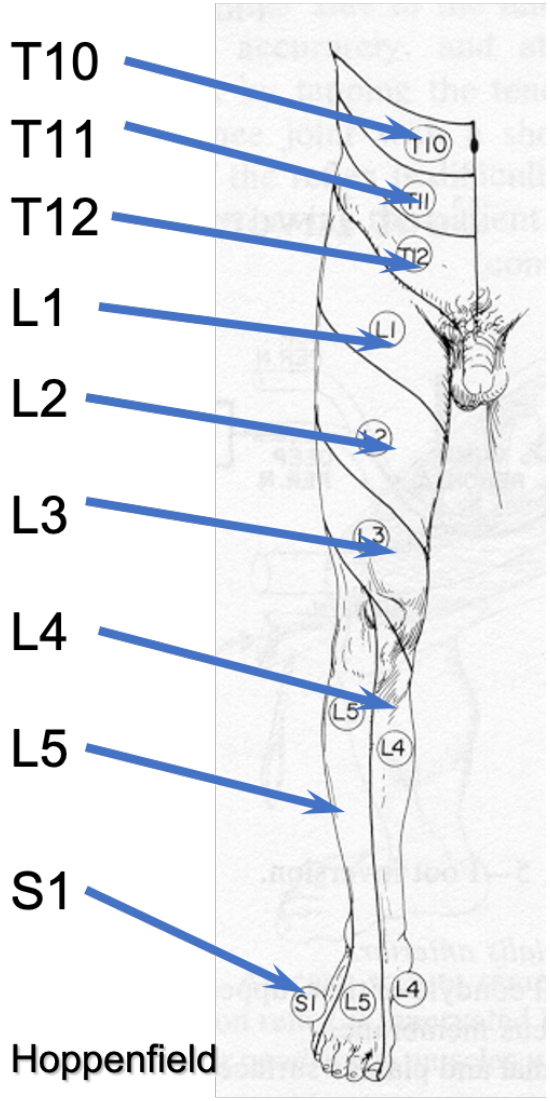
L4-L5 - Ankle Dorsiflexion

L5 - Great Toe Extension, Hip Abductors, Medial Hamstrings

L5 -S1 - Ankle Inversion

L5-S1 - Ankle Eversion

S1 - Plantarflexion, Lateral hamstrings



Examination continued

Neurodynamic testing

Flexibility

Special Tests- UMN, Instability, Motor Control, Pelvic floor, Distraction, Compression, SIJ, Hip

Your Patient findings

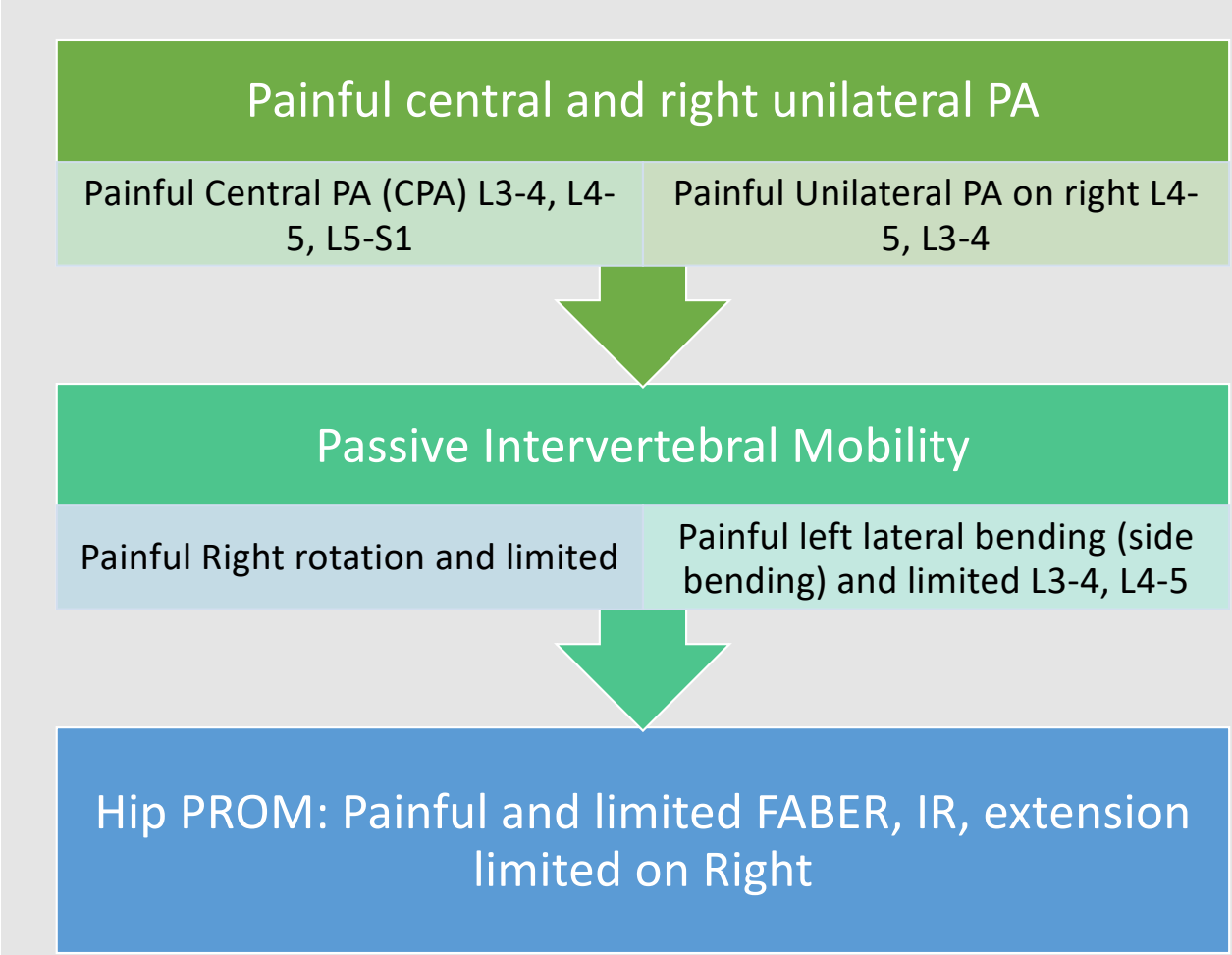
- **Inspection:** Decreased lumbar lordosis, standing with slight side bending to the left
- **AROM:**
  - Flexion: 50% pain in right lateral leg
  - Extension: 50% pain in buttock and lateral thigh, worse with repeated motions
  - Left lateral bending: decreased leg symptoms, increased back pain
  - Right lateral bending: Severe limitation increased back and leg pain
  - Left rotation: No change
  - Right rotation: Less lateral leg pain, increased back pain
- **Hip ROM:** Limited FABER, hip extension, IR on right
  - Decreased Lower back pain with long axis distraction of right hip

Demonstration:
PAIVM, PIVM

- PA Prone
- PA Unilateral (Transverse Process)
- Rotation in flexion initiated Cranially
- Rotation/Side bending initiated Caudally
- Flexion
- Side bending

Patient Findings:

Passive Mobility



Your Patient findings:

NORMAL

Neurological Screening

L1-S2 Myotomes- Normal

L1-S2 Dermatomes- Normal

L3-4, L5, S1 Reflexes- Normal

Your Patient findings

- Neurodynamic Testing:
  - Positive Slump
  - SLR- Pain in back, right buttock and lateral leg at 50 degrees right, negative to 70 on left.
- Flexibility:
  - Psoas, Quad tightness R>L

Your Patient findings

- Special Tests:
  - Decreased pain with Right long axis distraction
  - Elimination of back and right leg pain with left sidelying, Right facet Distraction
  - Poor control of pelvic floor with Kegel instruction and verbal confirmation of fatigue (fluttering)

  - Next Visit: Two Stage Treadmill Test-
    - WHY????

What Imaging findings might this patient have?

MRI- What does the Magnet Say????

- Therapist: “You had back pain for awhile, and there’s a fair amount we know about chronic back pain that we can discuss related to what’s going on with you.”

- Patient: “What about it?”

- Therapist: “Thanks for asking: The longer you’ve had it the harder it is to get better. There is not a magic bullet to treat, it. However, PT has been shown to be very effective using what I do, especially with the findings we have here today!”

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- Patient: “I’m worried about this because it seems like it is getting worse. I’m afraid exercise is going to make it worse. I’m also afraid I might need surgery and the doctor already mentioned epidurals. I just don’t want all that!”

- Therapist: “Well, you have come to the right place! Most of the time this improves, and there are some things I see right now that put you in the likelihood of therapy helping. Let’s give it a try. You might get a little sore with some of the things we do, and if there is anything that concerns you let me know. **This is not a torture tolerance test.**”

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Explanation of Findings:

- Pain with walking better with sitting- Stenosis (lateral foraminal in this case)
- Reduction of symptoms with distraction/mobilization of right lower lumbar area
- Reduction with long axis traction of hip and hip mobility (Treating hip hypomobility helps back pain)
- Patient goals:
  - Based on positions of relief we found, may be able to help sleeping position
  - Based on reducing pain, may be able to improve walking.

Development of Contract

- Patient specific Functional Goals (PSFS)
- 0-10 with 0 unable, 10 normal

Patient Specific Functional Scale	Score
Walking	2/10
Movement without Pain	2/10
Sleep	3/10
Average	2.33

- GOAL: Improve PSFS to 7/10 in 6 weeks

Development of Contract

- “I would like to treat this 1-2 times per week for 4-6 weeks. We should see some improvement in some of the Specific Functional problems you have in 4-5 visits. If not, we need to decide if PT is helping, or if there are other things in addition to PT to consider.”

- We should see improvement in your PSFS to 7 or 8/10 in 6 weeks, and a reduction in your Outcome Score by at least 15%.

- Then we might need check ups once in awhile should you have a flare up or need to tune up your exercises
- How does that sound?
- Any Questions?”

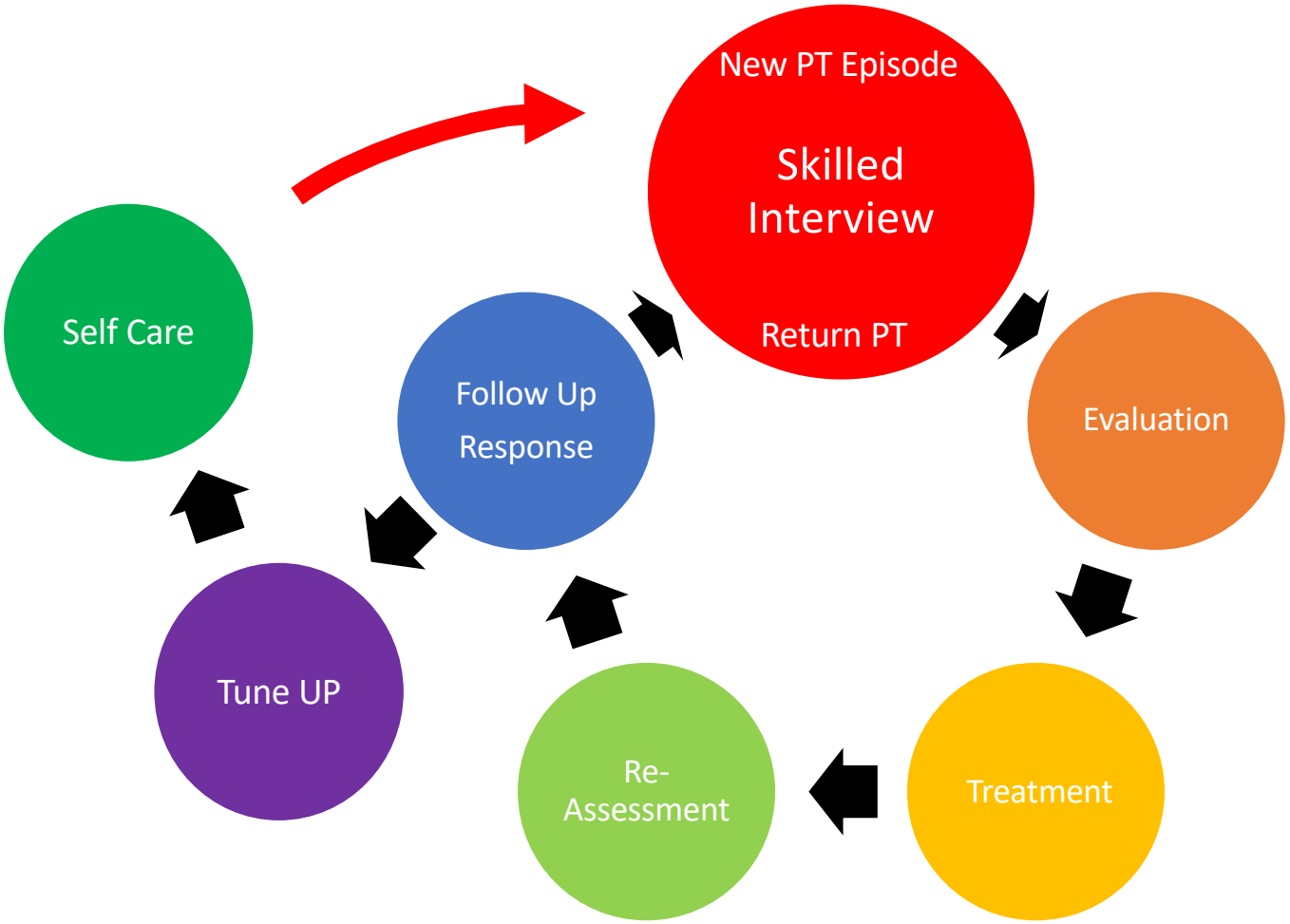
“Now I would like to try some simple treatments and discuss some things you can do at home to supplement what we do here”

- Manual therapy:
  - Side bending to left- Distract, mobilize right side
  - Rotation mobilization- Right rotation
  - Long axis to hip
- Sleeping position
- Posterior pelvic tilts
- Pelvic floor
- Sidelying positional distraction/self stretch

Don’t Give Up

- It’s going to be alright
  - It will likely improve
  - Water under the bridge
- Get Moving
- I Can’t do it for you, but I’m here to help
- Don’t give up

Continuum of Care




Questions???

Thank You!!

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