Promotion of early mobility in the patient with chronic pain

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Outline

- Introduction
- Evidence Background
- Screening and self-report tools
- Examination
- Manual techniques
- Therapeutic exercise
- Patient education
- Conclusion and references

Operational Definitions

-Early- in the disease process or plan of care?
-Mobility: “the ability to move or be moved freely and easily.”
-Chronic Pain: A chronic disease is one lasting 3 months or more, by the definition of the US National Center for Health Statistics
-Manual Therapy: joint mobilization/manipulation, soft-tissue mobilization
-Central Sensitization
Evidence review
- Physical therapy as an effective strategy for management of chronic pain
- Financial impact of physical therapy vs. medications, imaging, or procedures
- Which intervention is best? Exercise, manual therapy, education?

Evidence-Based Practice
Perhaps even more so than typical, those in the chronic pain population require use of all 3
As a therapist gains exposure to those in this population, they will learn from experience about conversations and methods which he or she may have success using.

Initial screening tools
- Demographic data and risk factors for Chronic pain, including central sensitization and disability include the following:
  - Female Gender
  - Fibromyalgia
  - Irritable Bowel Syndrome
  - Depression/Anxiety
  - High BMI
  - Duration of symptoms
- Self-report tools
  - Tampa scale of kinesiophobia
  - Catastrophizing score
  - FAB-Q
  - Cervical and lumbar disability questionnaires
  - Depression screening (Beck, 3 question)
Kinesiophobia

Central Sensitization

“The responsiveness of central neurons to input from unimodal and polymodal receptors is augmented, resulting in a pathophysiological state corresponding to central sensitization, characterized by generalized or widespread hypersensitivity.”

“An amplification of neural signaling within the CNS that elicits pain hypersensitivity.”

Often accompanies chronic pain conditions
Pain vs. nociception
Initial musculoskeletal nociceptive issue
Sensitization- Peripheral vs. central
Methods for detection/clinical screening

Examination
Concepts of manual intervention

<table>
<thead>
<tr>
<th>Therapeutic touch</th>
<th>Neurodynamics</th>
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<tbody>
<tr>
<td>Positive effects</td>
<td>Can be very complex, much more in-depth training available through several different sources</td>
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<tr>
<td>Adverse effects</td>
<td>General concept involves use of combined or isolated peripheral and central movements to affect remote changes via neuromodulation theory</td>
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<tr>
<td>Potential mechanisms behind benefit-</td>
<td>Biomechanical vs. neurophysiological</td>
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<tr>
<td>Placebo, expectation, and psychosocial factors</td>
<td></td>
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<tr>
<td>Does specific technique matter?</td>
<td>Use as continued assessment of both objective and subjective elements</td>
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Therapeutic Exercise Concepts

- Graded Exposure
  - Gradual increases in use of movements or positions that are perceived as threatening
  - Good research for use in chronic low back pain scenarios
  - Consider progression variables such as hold times, duration of activity, WB or gravity reduced positions

- "Early Mobility"
  - Depending on irritability, may be direct or indirect movement of primary region of complaints

Videos of therapeutic exercise elements
Videos of therapeutic exercise elements continued
Peripheral Considerations

Although more widely researched and considered in relation to the spine, chronic pain is also possible in the periphery.

Peripheral sensitization involves lasting up-regulation of nociceptive signalers

Consider possibility of Complex Regional Pain Syndrome in cases where hyperalgesia is noted

Techniques may include desensitization, neurodynamics, soft tissue techniques and graded therapeutic exercise

Patient education

Pain Neuroscience Education/Therapeutic Neuroscience Education

Utilizing appropriate and reassuring language is important- what does the patient hear when you say “degenerative”?

Framing the subjective examination- What level is your pain today? How are you doing?

Utilize helpful metaphors- "Hurt doesn't equal harm", "Pain is the body's alarm system".

Various online resources are available to patients including retrainpain.org. Useful resources must, however, be implemented alongside in-clinic strategies by provider

Majority of accessible patient-directed online information is, however, geared towards negative pathoanatomical mindsets.

Per APTA Statement on billing for patient education, "The time associated with providing skilled services in the form of patient education is reported based on the outcomes the physical therapist is trying to achieve with the patient education."

Implementation Keys

-Clinic environment- consider a private treatment room or a location in the gym that is more isolated.

-Use of techniques for treatment of multiple patients per hour vs 1-on-1

- Be mindful of your communication style, including body language and demeanor

- Above all, utilize clinical reasoning when implementing any treatment plan.

- Education, education, education

- Coding and ethics

- Parameters...?
Conclusion

- Resist the urge to panic or have a negative response during initial meeting/intake.
- Remember that you are helping an underserved population with significant needs.
- Practice and become comfortable with phrases and activity cues
- Ensure all other staff are familiar with goals and concepts
- Consider what is a successful outcome and how you measure that
- Physical therapy is only one part of the management program for chronic pain
- Ask Questions and Research!

References


References continued


References Continued

Taken from http://www.apta.org/Payment/Coding/FAQs/PatientEducation/
1/8/2018