

SPEAKER: Good morning. I'm the guy who makes people move, so if everyone can stand up for just a moment. I've always wanted to say this. All who are able, please rise. Give me some standing marches, squat down to your chair a little bit.

Heel raises, ankle pumps, neck rolls. All of the above are fantastic. I need blood flowing for the next 10 to 15 minutes.

So thank you for having me. I appreciate it. I want to talk about what makes up about 80% of my caseload. Except this time of year is concussion season, so that changes. But generally speaking. I have no disclosures besides that I am a part time instructor in the orthopedic department at Mount Union. And then I also work for a recovering CrossFit gym. That just means they've dropped the title.

I do have objectives, but I want to skip them because they're not as much fun as everything else. So I don't know how many people are going to catch the Jay-Z reference here. But if you do, chances are, we'd be great friends.

The entry level degree to be a physical therapist in the United States is a clinical doctorate, and that's been the case since 2007. Go Vikings. In about that same time, the American Physical Therapy Association established a goal that we would have direct access, so the ability to treat patients without a physician referral, everywhere in the country by 2020. And they got it done five years early. So with great power comes great responsibility. So we better know what we are doing.

This slide was a big musculoskeletal examination skills test. And the highest score was orthopedic physicians, and that includes surgeons. So I would certainly hope so. But the next few people in line, those are orthopedic clinical specialists, PTs, non-specialist students, and our masters-- trained, more seasoned therapists. I guess the psychiatrists serve as the control for this particular study.

So when someone comes to me via any route for neck pain, I'm going to screen them. So if it's a direct access patient who fell or had an MVA, I might be doing the kinds of things like you might do in the ED, looking to rule out fractures. I'm using clinical prediction rules and clustering of symptoms to consider things like myelopathy and radiculopathy as we've discussed. And possibly referring out

appropriately, or at least monitoring certain patients more closely than just good old fashioned pain, whatever that means.

There was a time when our profession was prescriptive. And that's no longer the case. And there was a time where everything was kind of cookie cutter, where everyone with neck pain got the same four or five stretches, everyone with low back pain got the same modalities. So when we started more pragmatically applying clinical prediction rules and algorithms, the outcomes predictably improved. That's just one example of that in 2003.

Which led to things like this, which are basically ways of categorizing patients. So your neck pain with headache might be your tension type headache. A person with a stiff neck might fall into neck pain with mobility deficits. So grouping these folks conceptually, and then we have different levels of evidence for the different kinds of treatments that we can provide for those patients helps guide clinical decisions. So no more cookbooks in my clinic.

This is another example of just the fact that passive modalities, while they do have some kind of a place and it's arguable how much of a place, that generally speaking, there are subsets of patients who benefit more from more specific treatment. And this was just an example of a cervical stabilization study. So for primary care providers in 2012, these are that were put out by the American Family Physician Association, I believe.

So if you look at this and how this relates to what we actually see in clinical practice, you know, essentially, this says that in the absence of red flags or other scary things that imaging may not be indicated, but everyone gets an X-ray, the general advice is to not rest. To rest for a while, but then get back to normal being a human being as soon as possible. I don't know too many other folks who view the world that way.

So part of that study, they looked at different adjunctive treatments from chiropractic to acupuncture, all these things. And my purpose in showing you this, besides taking any excuse to get Sylvester Stallone on the screen in a important presentation, is iDryNeedle, which is not the same as acupuncture but it's similar enough, I do soft tissue mobilization, which is what we call massage because we like typing more.

I have a traction machine. Exercise is always the foundation of what we do. So while you might send folks to one of these other disciplines, that is somebody wielding a hammer and everything looks like a nail. And my tool box is fairly diverse.

I would argue we have a pretty broad scope of practice, which invites variability, unfortunately. But it also gives us a lot of options. So I can apply these things pragmatically, and not so much all or nothing. I might two needles in a specific muscle and not 400 needles in your earlobe, great toe, and forehead.

These are the NICE guidelines, which are harder to read. But if you look at what they're recommending, down in tier three, exercise all day long and twice on Sundays. That is what we do best. Exercise is not something that comes from a pamphlet or from Dr Google.

Manual therapy treatment package, many of us use manual therapies to varying degrees of force and expertise. Psychological therapies, I was at a conference last week at a different hospital system, which won't be named. And there was a psychologist talking about chronic pain. And she said that due to the graded exposure sort of way that we do things, that physical therapists are psychologists and we don't know it. We know it. Trust me, we do. And then other treatments kind of come on down further the line.

So what I really want to do is look at someone's impairments in the context of which they have symptoms. So yes, they might have lumbar facet degeneration, but if they're walking with a lot of frontal plane sway and I'm able to help them get their lateral hips stronger and then their gait looks a little better, then, lo and behold, their pain oftentimes gets better. They might need improved stabilization, they might have pelvic floor dysfunction, they might have no hip internal rotation. So when they go to advance the other leg, their spine twists all the time.

So as Dr. Capulong said, we make jokes that I treat back pain all day. And I treat mostly hips. Most of what we're doing is hip oriented or in the neck. It's upper thoracic and parascapular. There's a whole lot of truth in that.

Because ultimately, I want to get people back to being able to do the things that make them who they are. You know, when we come out, we're all able to squat in

that position. And somewhere along the way, we lose these fantastic ranges of motion and strength. And a lot of that is just because of our lifestyles and the way that we choose to spend our time.

So I might not get everyone's squat back to looking quite like that. And everyone's grandma may not be dead lifting or threatening you in a meme. But I want to get these people back not just to, I don't hurt, but at least nudged along the way towards fitness, and not just away from sickness. I just threw that study in there because vigorous physical activity can help maintain intervertebral disc health. So not just Prancercise or gentle things, if applied pragmatically and appropriately.

Because what it ultimately comes down to is they don't come because they have facet degeneration, they don't come because their hip is tight. They come because they hurt. So we know that the old school Descartes model is pain is protective. A touch of fire, fire bad, pull my hand away.

People believe that their pain is always a threat. And until you've alleviated that concern, you know, threat perceived as real. So if someone's afraid to move, the advice to exercise is not going to get you very far, literally or figuratively. So if I can show somebody and get some small victories that they can move a little more or move without quite as much pain, then we can build momentum and get them further along that path to a better place.

So we've all shared different studies about the incidence and prevalence of spinal degeneration on imaging. I would like to draw your attention to the word asymptomatic. These are people without back pain. So whatever age you are, find your column and see what you are likely to have going on without knowing it.

I'm not here to freak you out, although this might do it. The presence of degenerative changes does not one to one equal pain, just like the fact that you have pain does not necessarily mean that there's something catastrophically wrong. And that's a very, very important concept for our patients to understand.

There is a small percentage that have hard neurologic symptoms, which we do screen for, that they need to go somewhere else in a hurry. But that's a fraction. If we screen appropriately, we're going to catch more of those than we miss.

So my favorite spinal researcher is Stuart McGill. He's the guy that puts all of the cadaver spines into machines and bends them a million times and sees how long it takes for them to fail. So he's kind of a weirdo, but the diagnosis of degenerative disc disease is akin to telling your mother-in-law with wrinkles that she has degenerative face disease. There's an awful lot of threat if you choose to do that.

And even if they do have that sort of thing going on, this study just came out. There's a chance that that disc will either reabsorb or break away and not be a problem anymore, on the order of as many as 2/3. And that was a 25-year study with 11 cohort studies included in Japan and the UK, I believe. So even if it's a thing right now, it may not remain a thing. These are people that were treated conservatively.

I apologize for the image. This was taken out of conference. This is not a back issue, this is after hip arthroscopy. So these folks all got seven days of tramadol after their hip procedure. And then this slide is what happened next. So if that next step on that first follow up as they go to see a PT, essentially, they use half as many opioids versus if that next step is the prescription of an opioid. They're going to use twice as much for almost three times as long and get more individual prescriptions thereof. This is my role in this conversation.

The best way to prevent chronic pain is to deal with it appropriately when it's acute pain. And that's what I like to think that we do a fairly good job of. So my take home messages are that we are not the prescriptive physical therapists of the past. Very few of us use passive modalities all that much. And if we do, it's sparingly.

We screen your patients, we evaluate and treat, we have a whole wide array of different tools in the box. So if your patients have tried and failed PT before, it is not a modality. I do not say a patient failed MD or a patient failed DO. So if you could remove patient failed PT from your lexicon, I would most appreciate it. If they've done it before, it's worth another try.

Last, I want to say to help me help you, if I have a patient who has had a surgery or ends up being someone who does, I look them right in the eye and say, you know what? That person does really great work, that surgeon is really, really good. You're going to do awesome.

Most of the time, that's a true statement, thankfully. I worked in Wyoming for a spell where that was much more of a stretch. And conversely, let's say somebody has to have four visits to PT before their insurance company will approve an injection. I would really appreciate it if you frame that in a way that it has a reasonable expectation of success.

I'm not saying to over promise and under deliver, but set me up and put it on the tee a little bit because you're going to make my life a little easier. And I'll do the same for you. Lastly, pain out there is almost never a lumber thing and it's definitely not a bursa thing. So stop injecting it. Thank you.