

From: James Beazell <jamesbeazell@orthopedicmanualtherapyseminars.com>

Subject: News from Orthopedic Manual Therapy Seminars

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May 2005

Orthopedic Manual Therapy Seminars Newsletter

Outcomes: Love 'em or Hate 'em

Dear James,

Outcomes: Do we need them or is it just a waste of paper and patient time? If one looks at the preponderance of paperwork that patients have to fill out, the amount of time that it takes to do so, frustration of both the patient and even the therapist, it is just easier not to do it!

On a day to day basis, it can be helpfull to therapists to look at screening, psychological measures, functional self report measures and the dreaded Visual Analog Scale for pain. These different measures can give you a snapshot of the patient's percieved functional level (it is a SELF report) and how they are coping with their injury.

Alan Jette, the interim editor of Physical Therapy, in a recent editorial spoke to the issue of lack of evidence in physical therapy. I had heard Dr. Jette talk about a meeting that he had attended with CMS with a number of therapists representing the rehabilitation community. The therapists were decrying the implementation of the 75% rule in rehabilitation. When the same therapists were asked by the committee if they had evidence of the hardship that this would supposedly put patients through or lack of proper care that would decrease the quality of life-none could be given. Dr. Jette states that we need to have a plan to implement outcomes and basic research in our field-as practitioners we can't wait for "researchers" to do this.

Fear Avoidance Beliefs Questionairre

Psychological Factors in PT

Waddell et al. published the first article on the use of the FABQ in Pain in 1993. At that time, Waddell began to explore the biopsychosocial aspects of low back pain. The research showed that some patients have fear of activity and fear of work related activity.

In a subsequent randomized control trial utilizing a specific evidence based booklet versus a traditional back booklet, Burton et al found that a specific intervention directed at these beliefs was more effective than traditional education. The authors concluded that carefully selected and presented information and advice about back pain can have a positive effect on patients' beliefs and clinical outcomes, and suggests that a study of clinically important effects in individual patients may provide further insights into the management of low back pain

George et al performed a RCT comparing standard physical therapy and fear avoidance beliefs therapy. They had 66 patients in the trial at 4 different clinics. The prediction of disability at 4 weeks and 6 months after treatment was significantly improved by considering the interaction between the type of treatment and the initial level of fear-avoidance beliefs. Both groups had significant within group improvements for disability and pain intensity. The fear-avoidance treatment group had a significant improvement in fear-avoidance beliefs, and fear-avoidance beliefs about physical activity were significantly lower than the standard care group at 4 weeks and 6 months after treatment. Patients with elevated fear-avoidance beliefs appeared to have less disability from fear-avoidance-based physical therapy when compared to those receiving standard care physical therapy. Patients with lower fear-avoidance beliefs appeared to have more disability from fear-avoidance-based physical therapy, when compared to those receiving standard care physical therapy. In addition, physical therapy supplemented with fear-avoidance-based principles contributed to a positive shift in fear-avoidance belief

http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=14652471

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Depression

Screening for Symptoms of Depression by Physical Therapists in Low Back Pain

The 2-item screening test was more accurate in screening for depressive symptoms than the physical therapists' ratings were; for example, in detecting moderate depressive symptoms in the 2 areas under the ROC curve, values were 0.66 versus 0.79. Discussion and Conclusion. Because the therapists did not accurately identify symptoms of depression, even symptoms of severe depression, despite the common presentation in their clinics, we recommend that physical therapists managing patients with LBP use the 2-item depression screening test. Administration of this screening test would improve physical therapists' ability to screen for symptoms of depression and would enable referral for appropriate management.

The authors point out that there is another depression short form screening tool. This is the Patient Health Questionnaire-2. The authors assessed construct validity in a cross-sectional sample of 1619 medical outpatients (mean age 43+/-14 years, 64% female) by comparing the PHQ-2 to four longer self-report questionnaires. Criterion validity was established in a subsample of 520 participants with reference to the Structured Clinical Interview for DSM-IV (SCID). Sensitivity to change was investigated in a prospective study of 167 patients who completed the SCID both at baseline and the 1-year follow-up. RESULTS: With reference to the SCID, the PHQ-2 had a sensitivity of 87% and a specificity of 78% for major depressive disorder and a sensitivity of 79% and a specificity of 86% for any depressive disorder. Its diagnostic performance was comparable with that of longer depression scales. PHQ-2 change scores accurately reflected improved, unchanged, and deteriorated depression outcomes. CONCLUSION: The PHQ-2 performed favorably with respect to a standard diagnostic interview, as well as established depression scales and proved sensitive to change. Thus, the PHQ-2 appears promising as a brief multipurpose measure for detecting depression, grading its severity, and monitoring outcomes over time

A number of self-administered questionnaires are available for assessing depression severity, including the 9-item Patient Health Questionnaire depression module (PHQ-9). Because even briefer measures might be desirable for use in busy clinical settings or as part of comprehensive health questionnaires, they evaluated a 2-item version of the PHQ depression module, the PHQ-2. METHODS: The PHQ-2 inquires about the frequency of depressed mood and anhedonia over the past 2 weeks, scoring each as 0 ("not at all") to 3 ("nearly every day"). The PHQ-2 was completed by 6000 patients in 8 primary care clinics and 7 obstetrics-gynecology clinics. Construct validity was assessed using the 20-item Short-Form General Health Survey, self-reported sick days and clinic visits, and symptom-related difficulty. Criterion validity was assessed against an independent structured mental health professional (MHP) interview in a sample of 580 patients. RESULTS: As PHQ-2 depression severity increased from 0 to 6, there was a substantial decrease in functional status on all 6 SF-20 subscales. Also, symptom-related difficulty, sick days, and healthcare utilization increased. Using the MHP reinterview as the criterion standard, a PHQ-2 score ≥ 3 had a sensitivity of 83% and a specificity of 92% for major depression. Likelihood ratio and receiver operator characteristic analysis identified a PHQ-2 score of 3 as the optimal cutpoint for screening purposes. Results were similar in the primary care and obstetrics-gynecology samples. CONCLUSION: The construct and criterion validity of the PHQ-2 make it an attractive measure for depression screening.

Staff Position

University of Virginia-Healthsouth has a staff opening for a physical therapist. We have a large outpatient orthopedic; that continues to facilitate relationships with University of Virginia orthopedics, physical medicine and rehabilitation, pain management and the community through our emphasis on manual therapy, education and exercise. There are multiple opportunities for program development and research.

Contact Jim Bezell, Clinical Coordinator 434-243-0311 james.bezell@healthsouth.com

Medical Exercise Training course June 4 and 5, 2005

Jim Bezell

Course still open for registration

"This course is designed to expose participants to the theory and application of medical exercise training following the system designed by Odvar Holten. It will address histological, physiological and neurological factors which influence the selection and progression of exercise, and will be lecture/lab format. Exercise prescription for the spine and extremities will be discussed, with precautions, contraindications and adjuncts to treatment included."

Mr. Evans is Clinical Director and Coordinator of Clinical Education in Miami, FL. He received his Bachelors Degree in Physiotherapy from Queen Margaret College, Scotland in 1991. He then worked in the outpatient orthopedic setting in Canada and the US before completing his Fellowship in Birmingham, AL with Dr. James Andrews. Alan has also completed four years of post graduate education in orthopedic manual therapy, through the Ola Grimbsy Institute, with whom he has served as an assistant instructor. He has lectured throughout North America and the UK. Mr. Evans teaches in both the shoulder and elbow curriculums. VPTA Type one hours have been approved Send payment to OMTS, 117 Bollingbrook Drive, Charlottesville, VA 22911.

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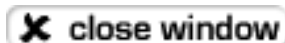
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