


ACC Forearm Guidelines Workshop, 14.06.09

Go on, twist my rubber arm

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Workshop Format

- Introduction to the guidelines
- Case study - Andy the forester
 - Discussion
- Case study - Megan the administrator
 - Discussion
- Wrap up



ACC Best Practise Evidence-Based Clinical Guidelines for the Primary Care Management of Distal Upper Limb Musculoskeletal Conditions

- Intention – injury prevention
- Primary Care – Diagnosis, Prognosis, Management
- Literature Review & Delphi consensus methodology
- University of SA



Key Points

Diagnosis – Hx, Exam: look, feel, move, special tests

Management – specific for condition

Management – address psychosocial factors

- physical reactivation

- address beliefs

- occupational focus



Diagnosis of Distal upper limb MSD

- Generally made on clinical grounds
- History - consider other determinants of the clinical presentation e.g. co-morbidities, work, non-work activities, psychosocial factors – beliefs & fears
- Exam – look , feel, move, special tests
- No place for imaging except ?USS in CTS
- Diagnostic quest may be unhelpful

'Patient-centred care' model

- Enabling & empowering patients through collaborative discussion and education
- Exploring patients beliefs, perceptions, expectations
- Considering the influence of social and cultural factors on their health
- "guiding" as opposed to "directing" style
- Goal setting when management is extended



Clinical Management Plan Aspects

- Specific diagnosis – specific treatment
- No diagnosis – symptomatic treatment & rehab
- Facilitate social participation
- Consider collaborative role of workplace
- Communication with workplace re fitness for work, including any modifications / restrictions - powerful if coming from GP (1)

1. Return to work knowledge base. <http://www.rtwknowledge.org>



Flags - Obstacles to Recovery

- Red – Biological
- Orange - Psychological disorders
- Yellow - Psychological responses and social interactions
- Blue - Individual perceptions about work
- Black - Social / Occupational obstacles (systematic)



Investigating Yellow Flags

- What do you believe is wrong?
- What do you think you should do if you get pain?
- What do you believe is required to help you?
- Have you been tense, anxious, or depressed?



Addressing Yellow Flags

- Education and reassurance
- Challenge beliefs & restore confidence
- Reactivation with pain management
- Consider early Psychological input
- A consistent message



Investigating Blue Flags

- Are you concerned that the demands of your work might delay your return to work?
- Do you think that your work could be modified temporarily so that you could return to work sooner?
- What kind of response do you expect from co-workers and supervisors when you return?

Shaw W et al. Early patient screening and intervention to address individual level occupational factors ("blue flags") in back disability. J Occup Rehabil 2009;19:64-80.



Addressing Blue Flags

Interventions – employer, individual, communication

- Determine problematic tasks from patient's perspective
- Brainstorm with patient – alternative duties
- Recognise stressful job elements / interpersonal conflicts
- Encourage patient to stay in contact with work
- Call the employer with consent - set expectations, reassure
- Look to facilitate communication & resolve conflict amongst all stakeholders - ACC

GPs in unique position to provide EBadvice about work

Strong evidence that return to work promotes rehab & improves general well-being(1)

Strong evidence that long periods out of work can cause or contribute to morbidity & mortality(1,2)

The longer anyone is off work, the lower their chances of getting back to work(2)

1. Waddell G, Burton AK. Is work good for your health and well-being? London: TSO, 2006.
2. The health and work handbook. Faculty of Occupational Medicine, Royal College of General Practitioners, Society of Occupational Medicine, London.
www.facocmed.ac.uk/librarydocs/h&w.pdf
3. Australian Family Physician 2009:38,No.1/2,Jan/Feb2009. Are sickness certificates doing our patients harm?

<http://www.racgp.org.au/afp/200901/29933>



Evidence supporting Rehab

At the 4-7 week stage rehab is likely to be the easiest, & most effective(1)

People with poor prognosis RTW better with intensive rehab (2)

RTW – address beliefs, phys. reactivation, occupational focus (3)

1. Frank et al 1996, 1998, Waddell & Burton 2000, Staal et al 2002, Campbell 2007
2. Haldorsen et al in Pain in 2002, Boersma & Linton in Clin J of Pain 2003, Sullivan et al in Physical Therapy 2006
3. Waddell – Back Pain Revolution 2004



ACC forearm guidelines

- Carpal tunnel syndrome
- De Quervains disease
- Epicondylitis
- Non specific forearm pain
- Olecranon bursitis
- Peritendinitis or tenosynovitis
- Primary Raynaud's phenomenon

Causation / Risk Factors

- CTS – median nerve compression, complex
- Tenosynovitis – repetition with force, pregnancy, postpartum, inflammatory e.g. Rheumatoid
- Epicondylitis – age, smoking, obesity, type 2 diabetes, repetition with force
- Non-specific forearm pain – female, white-collar, smokers, psychological distress
- Olecranon bursitis – acute trauma, friction, inflammatory or infective
- Primary Reynaud's – young females, FHx



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