

Is it time to reframe how we care for people with non-traumatic musculoskeletal pain?

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THE CURRENT APPROACH TO MUSCULOSKELETAL PAIN IS FAILING

The majority of persistent non-traumatic musculoskeletal pain disorders do not have a pathoanatomical diagnosis that adequately explains the individual's pain experience and disability. We contend this has resulted in two concerning developments in the management of people with such disorders. First, structural changes observed on imaging that are highly prevalent in pain free populations, such as rotator cuff tears, intervertebral disc degeneration, labral tears and cartilage changes, are ascribed to individuals as a diagnosis for their condition. In this context, this information may result in the individual believing that their body is damaged, fragile and in need of protection, resulting in a cascade of movement and activity avoidance behaviours and seeking interventions to correct the structural deficits.¹ This trend has led to exponential increases in elective surgery rates and associated costs, while the efficacy of repairing (eg, rotator cuff and medical meniscal tears), reshaping (eg, subacromial decompression) or replacing (eg, lumbar intervertebral discs) the structures considered to be at fault has been substantially challenged.²⁻¹⁰ Second, it is arguable that musculoskeletal clinicians have invented treatments for conditions that may not exist or be readily detected (such as trigger points, sacral torsions), and they have developed and perpetuated treatment paradigms (such as 'correcting' upper body posture and muscle imbalances) that do not conform to current research evidence.¹¹⁻¹⁴ These two trends have created an expectation that interventions (frequently 'passive') will provide a

'cure', and typically quickly, with minimal self-contribution. This expectation may have been derived from a conversation with a friend or family member, from the Internet or from an advertising campaign, but almost certainly originated from health professionals.

WHAT CAN WE LEARN FROM THE MANAGEMENT OF OTHER CHRONIC HEALTH CONDITIONS?

Contemporary evidence demonstrates that many musculoskeletal pain conditions are associated with long term disability that are often resistant to current treatments. They are influenced by multiple interacting factors, including genetics, psychological, social and biophysical factors, comorbidities and lifestyle.¹⁵ We propose that when these conditions become persistent and disabling they should be viewed in a similar way to other chronic health conditions. For example, when an individual presents with non-insulin dependent diabetes, best practice would involve an interview and examination where a diagnosis is reached and the relevant biopsychosocial contributing factors to the disorder are identified. Based on this, education, advice and shared decision making, a management plan, underpinned with empathy and support, would be agreed. This plan would typically involve highlighting the importance of good sleep hygiene, the role of nutrition and diet, stress management and, if relevant, cessation or reduction of smoking. The profound benefits of participating in appropriate graduated physical activity would be emphasised and, if necessary, medication, such as metformin, may also be prescribed. It also involves the management of comorbid health complaints. While, if required, the prescribed medicine would differ, the management of other chronic disorders, such as asthma and high blood pressure, would follow a similar process.

In the management of these conditions, the focus is not on providing a 'cure' but rather the discussion is about providing a 'management' plan to control the disorder and limit its impact on the

person's well-being. While the signs and symptoms of many of these chronic problems may reduce to the level that the individual no longer feels disabled or symptomatic, ongoing self-management is essential.

A NEW APPROACH IS NEEDED

We believe there is a need to reframe the way we care for non-traumatic persistent and disabling musculoskeletal pain conditions, by aligning the management of such conditions with the principles underpinning the management of other chronic conditions: strong clinical alliance, education, exercise and lifestyle (sleep hygiene, smoking cessation, stress management, etc) in order to build the individual's self-efficacy to take control and ultimately be responsible for their health. Although the arguments for such an approach are compelling,¹⁶ and evidence is emerging for a number of musculoskeletal disorders, it is acknowledged that definitive evidence for all musculoskeletal conditions is currently lacking. Such an approach would be supported by other and emerging evidence, translated from the available research for the condition being managed.

Reframed in this manner, patients would no longer be led to expect a 'magic' manipulation or other passive approach to 'cure' their condition, and this in turn may reduce stress and burnout experienced by many clinicians who are unable to deliver on such unsubstantiated promises. Interventions such as manual therapy, pharmacology and injections, when provided, should be seen as an adjunct, and their risks and benefits must be considered and honestly communicated.

OBSTACLES AND OPPORTUNITIES FOR THIS APPROACH

We need to reframe what is currently doable and achievable in the management of many non-traumatic musculoskeletal presentations, and honest and open conversations regarding the outcome evidence for these disorders needs to be sensitively communicated. There would be many obstacles to overcome and respect when considering such an approach. For clinicians, these might be pain beliefs, professional identity, time, financial pressures and lack of adequate training. Patient beliefs and expectations may also pose a significant challenge for clinicians, especially when they desire a structural diagnosis and a

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‘fix’ for their pain. For patients, creating an understanding and expectation that, as with other chronic health conditions, there is no magic cure for many persistent and disabling musculoskeletal pain conditions, and that ultimately ongoing evidence informed self-management is the key. To achieve this, the efforts of many institutions, including educational, healthcare, political and professional organisations, health funding bodies and the media, need to be involved.

We believe in the need to frame past beliefs against new evidence, and when in conflict we need to evolve with that evidence. We contend this requires those of us working in the musculoskeletal field to acknowledge the limitations of current surgical and non-surgical interventions for persistent and disabling non-traumatic presentations, as well as upskill and reframing of our practice, language and expectations to consider aligning our current practice with that supporting most chronic healthcare conditions. By doing this we can better support those members of our societies who seek care, and be more honest with the level and type of care we can and should currently offer, and the outcomes that may be achieved.

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GLA:D to have a high-value option for patients with knee and hip arthritis across four continents: Good Life with osteoArthritis from Denmark

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WHAT IS THE PROBLEM?

We know that we should be providing patient education, exercise and weight management for people with knee and hip osteoarthritis, but do we know what to do? GLA:D may provide an answer,

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Myth that persistent musculoskeletal pain with no obvious cause can be cured

Clinicians need to be more honest with patients about what they can really expect

It's a myth that most persistent musculoskeletal pain with no obvious cause can be cured, argue experts in an editorial published online in the ***British Journal of Sports Medicine***.

Doctors and other healthcare professionals need to be a lot more honest with patients about what they can really expect, write Professor Jeremy Lewis, of the University of Hertfordshire and Central London Community Healthcare NHS Trust, and Professor Peter O'Sullivan, of Curtin University, Perth, and Bodylogic Physiotherapy, Perth, Australia.

There's no magic fix and patients may have to live with their pain as they would any other long term condition, they say.

The fact that most persistent musculoskeletal pain that isn't the result of injury or trauma has no obvious cause has prompted the development of two unfortunate trends, the authors suggest.

Firstly, structural changes that are commonly seen on the x-rays and scans of people with no pain, such as rotator cuff (muscles over the upper arm bone) tears and intervertebral (spinal) disc degeneration, are often used to explain the pain.

This may not only prompt avoidance behaviours, but also a desire for corrective treatment, leading to unnecessary surgery on tendons, cartilage and bones that aren't the cause of the pain.

Secondly, some clinicians have arguably invented 'treatments' for conditions that may not actually exist or be readily detected, and for which there is no good evidence that they work.

"These two trends have created an expectation that interventions (frequently 'passive') will provide a 'cure,' and typically quickly, with minimal self-contribution," write the authors.

But the reality is that many musculoskeletal pain conditions are associated with disability and won't respond to current (passive) treatment. And they should be managed in the same way that other long term conditions, such as diabetes, are--with a focus not on providing a cure, but on minimising the impact on an individual's wellbeing, they suggest.

This includes lifestyle changes, such as stopping smoking and stress management, to enable that person to take control of their condition, rather than expecting the clinician to do this with various treatments.

"We need to reframe what is currently doable and achievable in the management of many non-traumatic musculoskeletal presentations, and honest and open conversations regarding the outcome evidence for these disorders needs to be sensitively communicated," they argue.

"For patients, creating an understanding and expectation that, as with other chronic health conditions, there is no magic cure for persistent and disabling musculoskeletal pain conditions...is the key...By doing this, we can...be more honest with the level and type of care we can and should currently offer, and the outcomes that may be achieved."

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