Continuing Professional Development for Osteopaths

OBJECTIVE ACTIVITY

Case-based discussion

Worked up example

Case based discussion: completed example

Title of case: JB
Name of osteopaths discussing: Steve Paterson/Jan Oscar
Date: 26.3.11

Brief description of case (all identifying details to be anonymised):

Clinical findings

There was no premonition of the symptoms, but there was an awareness of 'muscular tension' in the upper cervical region for some time following each episode. It was also reported that sudden extension or rotation movements through the cervical spine seemed to trigger headaches and that the patient felt very vulnerable when looking up.

Cranial nerve examination II, III, IV, V, VII, IX normal, although it was noted that the patient struggled to stand still with her eyes shut (postural nystagmus suggestive of poor proprioceptive feedback).

Forward head posture. Acutely sensitive suboccipital musculature, marked tenderness through C2/3 on the left although tissue tone was relatively poor through the overlying cervical erector spinae.

Tonic anterior cervical musculature, specifically in relation to the hyoid. Tenderness and acutely painful upper thoracic region, with trigger points found within the cervical extensor muscle attachments, serratus posterior superior, rhomboids and trapezius bilaterally. Palpation of these tissues seemed to reproduce some of the aching pain JB experienced following her migraines.

Active movements of the cervical spine were hesitant and poorly controlled. JB was unable to extend her head more than 10 degrees without feeling 'vulnerable', describing this as if she were unable to 'hold her head up' and being fearful of pain. However, all ranges of movement were possible, and passively there were no significant findings to suggest structural weakness.

Personal clinical issues

I found this case particularly challenging on a number of levels:

- JB had come to me looking to find out whether osteopathy could help her, having had many years of pain and subsequent 'disability'.
- There were numerous elements in the case that appeared related to JB's neck pain and headaches, but I was not sure what role they might be playing and whether, if I treated them, it would affect JB's symptoms.
- There were complex psychosocial issues in this case relating to JB's chronic pain, her apparent fear avoidance activity (an obvious yellow flag), her apparent isolation from her previous occupation and social life, and her role supporting her relatives.
- My scope of practice limitations. I recalled another osteopath in my local region who I knew had worked extensively with patients in a chronic pain setting, so I decided to contact her to discuss the case and to find out if she had any thoughts as to how I might manage this case, or if I should refer JB for treatment elsewhere.

The summary of our discussion and actions to be taken can be seen overleaf.

OPS Theme	Points discussed	Actions to be taken / Learning points to record
Communication and patient partnership	Identifying patient's expectations: One of the first things my colleague asked me was what my patient was expecting from osteopathy. I admitted I wasn't entirely sure, but I recognised that this would be really important in my establishing if my patient's expectations were beyond my scope as well as identifying factors that I might be able to influence. We agreed that it would be essential for these expectations to be discussed with JB, so that she and I would be able to decide on the best course of action for her care.	• To spend some time with JB discussing her expectations and what she hoped to gain from osteopathic treatment. • To identify aspects of her case that I felt I could influence and to discuss with JB the possible treatment, management and likely outcomes so that she would be able to decide if she wished to proceed with treatment. • Maintain an open dialogue with JB to ensure that our aims and objectives were shared and that her expectations were being met.
Knowledge, skills and performance	Develop my scope of practice: My colleague also discussed some helpful aspects relating to the current understanding of migraine headaches. She suggested I should read a couple of papers published by an osteopath, relating to managing migraine headache patients, as well as the latest guidelines published by the Scottish Intercollegiate Guidelines Network (SIGN) for the diagnosis and management of headaches in adults.	• Search the literature online for the SIGN guidelines and review the management of migraine. • Search online for the articles suggested, and any others that might help me to better understand the issues relating to

		managing migraine in osteopathy and healthcare in a broader setting.
Safety and quality in practice	Ensure quality of patient care: During our discussion, we explored approaches to treatment. It was agreed that during the initial stages of treatment, patients with such symptoms would probably be somewhat nervous of treatment. Consequently it would be important to treat the patient relatively non-invasively and to continuously look for feedback in relation to pain, the patient's perceptions of the treatments and any anxiety they might be feeling. It was also agreed that there would be a need to identify objective factors in the case that could be re-assessed and reviewed with the patient, so that goals could be monitored and progress recognised. The psychosocial aspects of the case seemed significant. My colleague suggested that I might like to set goals with the patient that might begin to allow her to become more socially active. One thing I thought might be amenable to change was her lack of confidence in her neck movements. My colleague suggested some simple exercises that might be useful in practice and that could give JB something to work on whilst outside the treatment room.	• Plan a staged introduction of treatment, with clear instructions to the patient with regards the experience of pain. Also to be aware of possible triggers for migraines and her trigeminal neuralgia, and to ensure that if the patient has any sense of risking a trigger to stop treatment. • Identify two or three elements that can be monitored for change during the course of treatment. Agree them with the patient and retest each one at every appointment. • Begin to look towards activities that the patient realistically feels able to take part in and, assuming there are recognised improvements, to try to take up that activity again.
Professionalism	Involve others in patient management: My colleague also considered whether the patient might	• To consider this further and to investigate

	benefit from referral to a pain management specialist. She reflected that for many chronic pain sufferers there was some good evidence that learning to develop personal strategies to live with chronic pain was helpful, although my colleague was unaware of examples for migraine and trigeminal neuralgia. See also B regarding reviewing and exploring the literature surrounding migraine/headache.	whether the patient has accessed such services already. Possibly consider writing to JB's GP and specialist (managing her trigeminal neuralgia) to explore these options further.

This osteopath also went on to undertake a detailed management plan.

Case-based - Clinical scenario

JB, a 40-year-old actress and singer, presented with a 15-year history of migraine-type headaches and a seven-year history of trigeminal neuralgia, along with upper back and neck pain and stiffness that she associated with her headaches. Five years ago her GP diagnosed her headaches as migraine-type headaches, and she reported that their severity had increased over a similar period. She was taking Naramig to help manage her symptoms. JB experienced her migraine symptoms three to four times a month, lasting anything from one to three days at a time. She described them as focused to one side of her head, though they could be left or right sided. There was an associated aching and stiffness reported in her upper thoracic and cervical spine region bilaterally. There was no premonition of the symptoms, but there was an awareness of 'muscular tension' in the upper cervical region for some time following each episode. It was also reported that sudden extension or rotation movements through the cervical spine seemed to trigger headaches, and the patient felt very vulnerable when looking up.

JB also presented with right-sided facial pain (previously diagnosed as trigeminal neuralgia), described as 'excruciating' and at times 'crushing and burning'. At its worst she said it was 'extreme'. Symptoms were located over the lower part of her face, particularly over her 'cheek bone'.

The primary reason for JB attending the clinic was to find out if there was anything an osteopath could do to help her, particularly as she felt that there appeared to be a relationship between her headaches and her neck. It was clear from the description of her symptoms and their effect on her life that her symptoms had significantly affected her way of life. JB appeared very anxious about her pain. She chose to wear a face mask to protect her jaw from exposure to the wind, and the debilitating nature of her migraines and facial pain had resulted in her feeling unable to work, and these prevented her from taking part in her previous social activities. Things were made more difficult in that she lived at home with her mother and sister, both of whom were registered disabled.

My examinations failed to indicate any significant abnormalities with the nervous system, although I noted a postural nystagmus when JB stood with her eyes closed. Physical examination revealed a forward head posture and poorly controlled cervical spine movements, especially into extension. JB described these as making her feel extremely vulnerable and as if she could not support her head. She also had acutely tender tissues in the upper thoracic and cervical spine that on palpation seemed to reproduce her neck and head pain.

Following my examination, I felt that there were elements to her case that suggested that osteopathy could help. We discussed her current treatment and the problems she faced with managing her pain. However, I was unsure precisely what I might realistically be able to achieve.

I discussed with JB what I felt could be treated and explained that I did not know what effect treatment might have on her migraines. We agreed to start a course of treatment for her upper back and neck pain, which we would monitor to identify any change. I also contacted a local osteopath that I knew to discuss her approach to managing complex head and neck pain.