

**FEATURE COMMENTARY****How to Become the Jedi Master of the Unchanged Derangement: Sticking with the System When the Going Gets Tough***Linnet Kazemi, PT, Dip. MDT*

Does this experience sound familiar? Your patient leaves day one and you're certain of their provisional classification of Derangement. Yet, the patient arrives on day two unchanged. You scratch your head and think, "What went wrong?" It is at precisely this moment that early in my MDT training, I would've cut bait reverting to some familiar, yet unsupported, treatment. Whether this was due to lack of knowledge or pressure from the ticking clock, thankfully, I now know better. However, I witness this trend in the clinicians around me, throwing the system out when the going gets tough rather than trusting the reassessment process. Using the guidelines below will ensure that by the end of the second visit, the patient is invested in their treatment plan and happy to pay their copay.

McKenzie and May speak of multiple dimensions for reassessment in patients with extremity or spinal pain starting with reassessment of symptoms and mechanics (McKenzie & May 2003). Thorough assessment of symptoms with variables such as frequency, intensity and location of symptoms as well as any changes in medication consumption, differences in ease of daily activities or ability to sleep can help guide your clinical decision making (McKenzie & May 2003). Regarding mechanics, note any changes in the range of a previously obstructed movement, a movement deviation or the intensity of pain associated with a movement (McKenzie & May 2003). Clarifying mechanics thoroughly is crucial as this may be an area of change that the patient is unable to identify for themselves. Next, confirm the patient's frequency and technique of their home program as a source of possible error before venturing further (McKenzie & May 2003). It is imperative to determine the lasting effect the home program has on the patient's clinical presentation as they may only be focused on the during movement response (McKenzie & May 2003).

Once you've determined your patient is unchanged, the fun begins. You get to dig in and do the work, but where do you start? What is the analytical road map you will use to make your outcome on day two more successful? A good starting point, if you are dealing with an extremity problem, is to confirm your location as pain in the extremities may have a spinal component (McKenzie & May 2000). As well, imaging studies have been found to be unreliable in determining the true pain generator (Reilly et al 2006). Therefore, performing a thorough screen of the appropriate spinal area is imperative in those patients with extremity pain (McKenzie & May 2000). Have you spent the time to appropriately rule in or out a possible spinal component as the answer may only become clear once the movement has been tested over a longer period of time (McKenzie & May 2003). Make sure you use appropriate communication with both the patient and the doctor regarding your findings if you do suspect a spinal component to keep everyone on the same page. Education is the key to maintaining trust with your patient and referring doctor (McKenzie & May 2003).

Once you've confirmed location, assess the provisional classification reached at day one. Evaluate yourself. Did you mistakenly jump into treating the patient before you fully understood what they were presenting with? This was an area of weakness for me prior to the diploma program. One of the best pearls of wisdom I learned during my time in Austin was, "Don't try to fix them. Try to understand them." Are you asking questions on the evaluation that will help you better understand what the patient is presenting with? Remember, it's a fireside chat but no one wants to be in a conversation with the person that never stops talking. Get the information that you need by listening to the patient and asking the appropriate follow up questions (McKenzie & May 2003) and move on.

The same holds true for the physical exam. Grade yourself. Are you on automatic pilot habitually performing the movement assessment? Or, do you systematically pick which movement will provide you with the most information in order to divide and conquer the puzzle before you? Review how you reached your provisional classification. If you concluded the patient presented with a derangement, was that because you witnessed a change in pain location and /or intensity or a rapid improvement in the range of a movement that was previously obstructed (McKenzie & May 2003)? If you were unsure after the history taking as to what you were dealing with, did you choose to explore flexion, in the case of spinal pain, and as a result, worsen symptoms or obstruct movement (McKenzie & May 2003)? Bottom line, do you feel confident with the classification that you chose? Does your assessment form demonstrate sound evidence leading to a conclusion of derangement such that if viewed by another clinician it would clearly lead them to the same outcome?

Your next step would be an analysis of direction. We know reducible derangements present with a directional preference, “postures or movements in one direction decrease, abolish or centralize symptoms and often increase a limitation of movement” (McKenzie & May 2003). On day one, did you find the direction of movement that brought about a lasting improvement in the location or intensity of the patient’s symptoms? Revisit this again and confirm that as a result of the movement the patient is performing you see a change in their symptoms or mechanics. If not, you may need to explore other movements in the sagittal plane or move to step four in order to exhaust it and determine the need for a lateral component (McKenzie & May 2003).

Your final step is to explore force. Did you get the patient to end range on day one to confirm the direction or expose a relevant lateral component (McKenzie & May 2003)? If not, now is the time to do so in order to assess the effect on the clinical presentation. Having explored force progressions, could you possibly need a force alternative? Would this patient get a better result by doing more sets every 2 hours or more often throughout the day (McKenzie & May 2003)? This is where you get to fiddle with the program in order to best tailor it to the patient that is sitting in front of you.

Systematically moving through this analysis, rather than becoming frustrated when a patient with a derangement returns unchanged, will allow you to be confident in the program you are designing for the patient. At the same time, it allows your patient to see the cause and effect their home program has on their symptoms and buy into it making them more compliant (McKenzie & May 2003). As you navigate this journey, allow the symptoms and mechanics to guide you. Be the “Jedi of clinical presentations” and leave your biases at the door. Then, if or when the next patient presents unchanged, you will reach for your detective hat rather than the estim. Good luck and as they say, “may the force be with you.”

McKenzie RA, May, S. (2000). *The Human Extremities: Mechanical Diagnosis and Therapy*. Waikanae, New Zealand: Spinal Publications New Zealand Ltd.

McKenzie RA, May S. (2003). *The Lumbar Spine: Mechanical Diagnosis and Therapy*. 2<sup>nd</sup> ed. Waikanae, NZ: Spinal Publications New Zealand Ltd.

Reily, P, Macleod, I, Macfarlane, R, Windley, J, Emery,RJ. (2006). Dead men and radiologists don’t lie: a review of cadaveric and radiological studies of rotator cuff tear prevalence. *Ann R Coll Surg Engl*; 88(2):116-121