Medical Screening Cases

Case 1 - treat

* Deliver this case to the room. Ask what sounds musculoskeletal. Ask what sounds non musculoskeletal.
* Deliver the Analysis
* Outcome – Patient treated with manual therapy and exercise and had a full return to function pain free in 6 wks.

Case 2 – Treat and refer

* Deliver this case to the room. Ask what sounds musculoskeletal. Ask what sounds non musculoskeletal.
* She has made minimal progress in 3 wks and 7 visits. She does not want to see a physician and has a race in 3 weeks.
* Outcome – Referred to non operative orthopedist. Goal was to determine if she could run the race or not. He performed 1 test (single leg hop) and set her up for an MRI. MRI revealed a proximal femoral neck stress fracture. Patient had no hip pain or signs with screening. No fulcrum or other boney integrity testing was performed in the exam.
* Lab
  + Show fulcrum testing for the femur
  + Vastus lateralis soft tissue – Have them do what they normally do and have them compare it to a sheering/peeling technique.
  + Medial Patellar glide – Show variation with rotation or traction.

Case 3 – treat and refer

* Deliver this case to the room. Ask what sounds musculoskeletal. Ask what sounds non musculoskeletal.
* Work through the analysis as a group.
* Outcome – Symptoms were classic trochanteric bursitis with ipsilateral LBP. L4-S1 facet stiffness and [+] Lx pain reproduction. Responded to soft tissue work and hip mobilization in treatment. Pain remained improved for 2-8 hrs and then would return. Primary therapist transferred to another clinic at 1.5 wks into care. New grad PT took over the case with specific instructions to call if the patient did not improve. 3 wks into care, no change in the patients pain or functional complaints. New grad PT was advised to notify the referring PCP. PCP was called, situation was described, and asked “How would you like us to proceed?” PCP advised to send patient back to him for imaging but to continue PT. Care was stopped after Xrays and patient became non-compliant and did not return PT calls. 2 wks later, patient called and revealed a recent diagnosis of proximal femur bone cancer. Pt DCd to oncology care.
* Lab
  + Practice the glute med soft tissue work – Show variations for glute med soft tissue
  + Practice hip PA’s – 1-2 variations.

Case 4 – treat and refer- wasn’t successful.

* Deliver this case to the room. Ask what sounds musculoskeletal. Ask what sounds non musculoskeletal.
* Work through the analysis as a group.
* Outcome – Pt was thin, extremely active with exercise, cared for 5 kids, and was in extreme pain (8+/10). Pain was unresponsive and inconsistent medically. Patient self DC’d and went to see another Orthopedist. She was originally referred by an orthopedist. She received an MRI and revealed discitis. She started an antibiotic and was 90% improved by week 3. She had had extensive dental work 2 wks prior to the initial onset. Not sure if there was a connection, but this was a hypothesis from the 2nd MD. Pt did not return to PT.
* LAB
  + Perform a mobilization to effect L4-5
  + Perform a mobilization to effect L4-5 in another position
  + Perform distraction in each of the 2 positions.

Case 5 – treat and refer

* Deliver this case to the room. Ask what sounds musculoskeletal. Ask what sounds non musculoskeletal.
* Work through the analysis as a group.
* Outcome – pt was referred by an orthopedist originally. Pt was advised to contact their PCP related to the redness and itching on her legs. PT notified the PCPs office of the quickly spreading rash on legs. PT notified the orthopedist of the new onset rash and the referral to PCP. Pt was diagnosed with cellulitis and they started an antibiotic. PT was continued within the same week of referral to PCP. Overall improved 60% with PT. Severely arthritic in bilateral hips and LX. She improved with hip distraction, general movement, and lumbar distraction.
* Lab
  + Hip distraction without ankle grip
  + Adductor soft tissue mobilization
  + Skin mobilization – distraction and gliding. Aim for an example with shoulder, knee, or Lx pain with reassessment after skin mobilization.

Case 6 - Treat

* Deliver this case to the room. Ask what sounds musculoskeletal. Ask what sounds non musculoskeletal.
* Work through the analysis as a group.
* Outcome – Costochondritis – Patient responded to costosternal rib mobilization, thoracic mobilization, and scapulothoracic strengthening over 4 wks.
* Lab
  + Palpate costochondral joint line vs. rib.
  + AP rib mobilization
  + Show appropriate approach to anterior chest palpation/treatment
  + Pec major bowing soft tissue mobilization

Case 7 - Refer

* Deliver this case to the room. Ask what sounds musculoskeletal. Ask what sounds non musculoskeletal.
* Work through the analysis as a group.
* Outcome – No response to PT and referred back to referring PCP. Referred to cardiologist by PCP. Highlight the lack of objective findings.

Case 8 - refer

* Deliver this case to the room. Ask what sounds musculoskeletal. Ask what sounds non musculoskeletal.
* Work through the analysis as a group.
* Outcome – No objective findings and no imaging hx. Referred back to PCP. Eventual diagnosis of Lung CA.
* Lab – Assess rib expansion laterally and AP. Aim at directional practice and test/retest thx mobility, LX AROM, Shoulder ROM.

Case 9 – refer

* Deliver this case to the room. Ask what sounds musculoskeletal. Ask what sounds non musculoskeletal.
* Work through the analysis as a group.
* Outcome: complaints are musculoskeletal but there is an absence of trauma and a positive family history for systemic diseases. Limited musculoskeletal findings. Presence of night sweats indicates need for medical referral. Symptoms worsened and patient was dx with regional enteritis (chrons disease). Medication reduced abdominal inflammation and eliminated subjective report of pain with hip flexion.

Case Study 10 – refer

* Deliver this case to the room. Ask what sounds musculoskeletal. Ask what sounds non musculoskeletal.
* Work through the analysis as a group.
* Outcome - Recommend testing blood sugar if possible. Symptoms have similarities to diabetic ketoacidosis. This would warrant sending to physician immediately without therapy. Patient should not drive.

Case Study 11 – Treat and monitor HA

* Deliver this case to the room. Ask what sounds musculoskeletal. Ask what sounds non musculoskeletal.
* Work through the analysis as a group.
* Outcome – Pt responded well to manual therapy and exercise to cx/thx and upper quadrant strengthening.
* LAB
  + C1-2 mobility testing (if time and engagement are present)
  + CO-1 mobilization to improve HA

Case Study 12 – refer

* Deliver this case to the room. Ask what sounds musculoskeletal. Ask what sounds non musculoskeletal.
* Work through the analysis as a group.
* Outcome – Pt referred to MD. Benign prostatic hyperplasia. Treated with medication.
* Lab
  + Lx AROM with OP
  + Hip AROM with OP