Pathoanatomy vs Psychosocial– Back to the Future?

With Dr Mark Laslett, Dr Angela Cadogan & Flavio Bonnet

On the 18th March 2019, Dr Mark Laslett and I were involved in a live social media discussion about the relationship between patho-anatomic diagnosis and psychosocial factors hosted by Flavio Bonnet from the Agence EBP.

We streamed live on Facebook, Twitter and Instagram (in English) from Christchurch, New Zealand. The event was viewed by more than 7,500 people from around the world.

We discussed four main topics. In this series I have provided a summary of the transcript for each topic.

1. Is it possible to make a diagnosis?
2. Does the pathoanatomic approach ignore the psychosocial aspect of the pain experience?
3. What do you say to colleagues who say that diagnosis does not change treatment?
4. How does imaging relate to diagnosis?

Link to video on Twitter: https://twitter.com/marklaslett_NZ/status/1107733389300240384

PART 3: What do you say to colleagues who say that diagnosis does not change treatment?

SUMMARY:

- *Diagnostic process is important to exclude serious pathology in primary care settings. These pathologies influence treatment (cancer, rheumatoid arthritis etc).*
- *Diagnosis **does** change treatment for many conditions.*
- *Many acute LBP conditions may not need a specific diagnosis and can be managed with guideline-based care. However, if the patient is not progressing "diagnosis" becomes more important.*
- *Diagnosis is important in traumatic shoulder injuries to identify conditions that require early surgical management (e.g complete subscapularis tear) or when it will alter prognosis.*
- *A specific diagnosis is not required when it doesn't alter management or prognosis. E.g subacromial bursitis, supraspinatus tendinopathy, atraumatic partial-thickness, or small, full-thickness tear.*

Dr Mark Laslett:

- Primary care is the entry point for a whole range of patients from simple/acute to chronic/complex disorders.
- For patients with acute pain, for example a back 'twinge' from gardening, presenting to primary care, no you don't need a diagnosis for those patients in most cases. Guideline based care is sufficient and they are likely to get better by themselves.
- For patients with long-standing pain, a diagnosis is required to inform referral and treatment decisions e.g:
    - Medial branch blocks to confirm facet joint pain
    - Antiobiotics (for modic changes/infection in anterior column)

- Spinal fusion (in small proportion of patients)
- You cannot make these decisions without a diagnosis.

- Some conditions are managed differently. Differential diagnosis is therefore important in some instances: e.g

Red Flags	Radicular syndrome	"Non-specific" Low Back pain
Infection	Radicular pain only (e.g Treatment with trans-foraminal epidural injection)	Facet joint pain
Fracture	Radicular pain and radiculopathy (Treatment with natural history, centralisation etc)	Anterior column pain
Cancer	Radiculopathy (no pain) (Treatment: no treatment, or surgery)	SIJ pain

Dr Angela Cadogan:

Do we need a specific diagnosis for shoulder conditions?

- If it changes treatment or prognosis then diagnosis is important: e.g

Diagnosis Informs Treatment	Diagnosis Does Not Alter Treatment	Diagnosis Informs Prognosis
Cancer Systemic inflammatory disease		Cancer Systemic inflammatory disease
Cervical spine referred pain vs cervical radiculopathy		
Acute, traumatic complete subscapularis or multi-tendon tear (requires surgery)	Atraumatic bursitis, partial thickness cuff tear, tendinopathy (all managed in a similar way)	Frozen shoulder vs Osteoarthritis.

- Diagnosis them is important when it will change your management or prognosis:
  - Surgical versus non-surgical
  - Education about activity modification in certain conditions will vary e.g AC joint arthritis vs rotator cuff conditions
  - A patient is more likely to 'buy in' to treatment for glenohumeral osteoarthritis if they are aware of the prognosis (worsening over time) and don't see 'worsening' as a failure of treatment.