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?

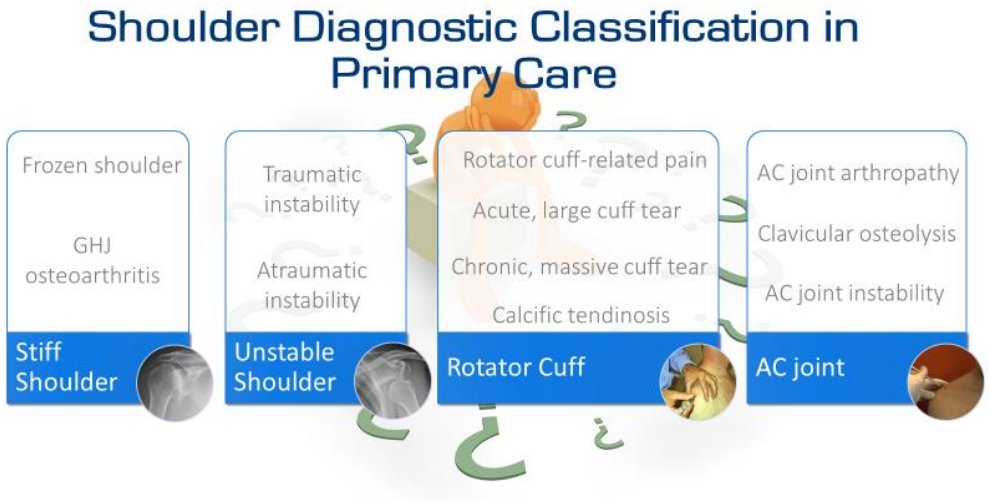
Link to video on Twitter: https://twitter.com/marklaslett_NZ/status/1107733389300240384

General Questions from Social Media

Click on the link below to go to the place in the document:

Specific vs non-specific "pain"

- *(AC)* There are some patients for whom you will never make a clear, specific diagnosis and that's OK, as long as you have excluded all the important conditions.
- *(ML)* modifying factors including significant distress may also mask diagnosis and make this difficult
- For patients without a specific diagnosis, symptom-based treatment approaches are definitely the best treatment
    - However, you would be doing the patient a disservice by failing to identify a specific condition that may respond to an additional or alternative treatment approach and help them achieve a faster outcome
        - E.g corticosteroid injection, or fenestration for calcific deposits in the shoulder, or directional preference in the lumbar spine.
- *(AC)* we cannot make a certain, specific diagnosis for most shoulder pathologies, so the approach I use in the clinic is to use a clinical subclassification system:
    - A "Stiff" shoulder
    - An "Unstable" shoulder
    - Rotator cuff-related pain
    - Acromioclavicular joint pain



Comment from David Poulter: "So in the clinic we are limited to our best probability of a diagnosis"?.

- *(ML)* Correct. We are manipulating probability.
- The probability of a patient having a particular diagnosis is the same as the prevalence of the condition in that population.
    - We know that the prevalence of discogenic pain in the low back pain population is about 40%. So when the patient walks in the door, there is a 40% chance that's what the patient will have
    - If the patient is over the age of 70 and has unilateral back pain the prevalence of facet joint pain is quite high
    - All our clinical assessment does is raise or lower that probability based on the results of individual tests. We never get to the point of 100% certainty, but we can shift our confidence towards more certainty based on the use of clinical tests with known validity.
    - But you don't have to have 100% certainty in order to commence treatment.