Facing the challenge of musculoskeletal pain

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Musculoskeletal pain and disability are among the most common problems managed by general practitioners, and present some of the greatest challenges to general practice. Effective and efficient strategies are needed.

In managing acute, self limiting musculoskeletal pain and disability, the major focus is usually on determining which structures have been injured and what can be done to make the patient comfortable and reassured while nature takes its course. However, this model is usually too simplistic to successfully manage chronic pain. There is often no evidence of ongoing injury in the investigation of patients with chronic musculoskeletal pain, and the presence of degenerative changes is so common in the pain free state that it is difficult to confidently attribute the pain to them. Radiologically guided injections of local anaesthetic can increase diagnostic confidence about treatable pathological sources in some patients, but for most, it is more practical to take an approach that examines for dysfunction, ie. disturbances in the function of the involved structures.

However this approach is still too simplistic. In dealing with chronic musculoskeletal pain and disability it is vital to acknowledge the multidimensional nature of pain. People in pain experience suffering and communicate this to others with behaviours ranging from wincing and guarding to stoicism and withdrawal. Such suffering and behaviour depend on past experience and how pain is perceived in the brain. The transmission of pain is powerfully modulated at the spinal level by input from both peripheral structures and from higher centres dealing with attention and emotions. The term ‘musculoskeletal medicine’ could be improved by extending it to the term ‘neuromusculoskeletal medicine’, to remind us of the crucial role of the nervous system in the perception and modulation of pain. This term could be extended further to recognise the role of the endocrine system through cortisol and catecholamines, but let’s not make it too much of a mouthful!

Postgraduate education in the diagnosis and management of musculoskeletal disorders offers the key to making this area of general practice more rewarding for GPs. My own experience of this began in 1989 with a weekend course on spinal pain presented by John Murtagh. This gave me the knowledge, skills and increased confidence to get better outcomes and so see musculoskeletal problems in a new light. They became a fascinating and rewarding part of my practice. Together with Clive Kenna, John Murtagh made a major contribution to musculoskeletal medicine in general practice by running courses in spinal pain for over 1500 GPs throughout Australia in the 1980s and 1990s. Courses have been continued by a small group of doctors, some of whom are contributors to this issue of Australian Family Physician.

Courses will soon become more available through an educational initiative for GPs throughout Australia by the Australian Association of Musculoskeletal Medicine and the Australian College of Physical Medicine. New developments are also occurring in education about musculoskeletal problems at medical school and postgraduate levels. In an effort to address the deficiencies and inconsistencies in medical school curricula on the musculoskeletal system, the Federal Government Department of Health and Ageing is funding an initiative to set national core competencies for musculoskeletal basic and clinical science. In the current review of The Royal Australian College of General Practitioners Curriculum for General Practice, the component on pain management has been greatly enhanced and, more recently, a musculoskeletal medicine working group has been established. This will encourage a higher level of training and provide the materials to support this.

This issue of AFP offers another opportunity to advance the knowledge and skills of GPs in dealing with musculoskeletal problems through a suite of very practical articles. There are articles on: the features of referred spinal pain and strategies for differentiating this from other sources of pain; strategies for the management of hip and shoulder pain; the role of gait and posture as risk factors for musculoskeletal pain; sports medicine versus musculoskeletal medicine; and musculoskeletal ultrasound. I hope that the insights gained from these articles will make the challenge of musculoskeletal pain less daunting for practitioners and their patients alike.

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