

## Case report

# Lack of confidence in the lower limb: Cognitive Functional Therapy (CFT) for a unilateral loading impairment in chronic non-specific low back pain. Case report



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## ABSTRACT

This case report presents the effect of Cognitive Functional Therapy (CFT) in a patient with chronic non-specific low back pain associated with unilateral loading impairment of the left lower limb. The patient believed surgery was the only possible way to treat the cause of the problem. The management of this idea was to change such belief. Manual therapy and active exercises were combined in order to encourage the patient to trust his back and lower limb again. One month and a half after the first appointment, the treatment resulted in complete absence of pain and disability. The patient returned to work and he was able to climb stairs and load his left limb normally.

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## 1. Background

Cognitive Functional Therapy (CFT) is a multidimensional biopsychosocial approach for the management of patients with LBP (O'Keefe et al., 2015; Rabey et al., 2015). There are many different patterns of maladaptive functional behaviours described in O'Sullivan's Multidimensional Classification System (O'Sullivan, 2005). One that could exist in isolation or combined with another pattern and is poorly described in the literature is loading impairment (Vibe Fersum et al., 2009). Therefore, the aim of this case report is to describe the pattern and also present the effect of CFT in a patient with unilateral loading impairment experiencing chronic disabling LBP.

## 2. Methods

### 2.1. History

A 49-year-old male dental surgeon who used to have a normal life, which included exercises at the gym and soccer matches, presented with six years of disabling low back pain. Once after

playing with his children in a pool, he started to feel unilateral pain in the lower back. In the same day, the pain worsened and disturbed his sleep at night. It was even necessary to get up to take some painkillers. The following morning he woke up feeling numbness in the left lower limb. The patient saw a physician and he was referred for x-ray and magnetic resonance imaging (MRI). The MRI showed two prolapsed discs L4/L5 and L5/S1. The doctor recommended surgery, but the patient decided to look for another treatment option. The patient was treated with acupuncture, global postural reeducation (GPR), and hydrotherapy, and he also lost some weight. The patient was absent from work for 30 days and then came back gradually. He did not return to the gym or play soccer because he still had discomfort in his back. Such discomfort and also the disability were reported to have persisted during the six year gap between the first and the second acute episode of low back pain.

The second episode occurred after bending over to pick a bottle inside the refrigerator. He felt pain on the left side of the lower back and down his left thigh and knee anteriorly, but without numbness (Fig. 1). He avoided walking for almost 30 days and was sent for another x-ray and MRI. The results showed degenerative changes in the segments L1/L2, L4/L5, and L5/S1 (Fig. 2). The doctor said that the only way to solve the problem would be surgery, due to the disc degeneration and the narrowing space compressing the nerve. The

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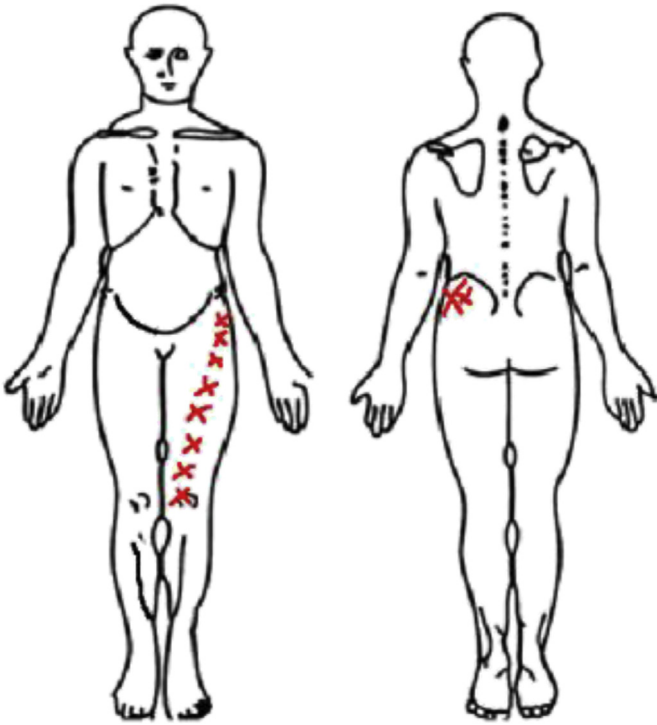


Fig. 1. Symptoms drawn on the body chart by the patient.

patient took some rest and medication. He was treated with acupuncture, and he started to walk with little pain.

“He (the surgeon) told me, “The surgery, you will not escape from it. Everything is treating the effect. It is taking your pain away,



Fig. 2. Second magnetic resonance image.

but is not solving the cause that is a matter of wear and tear” (Video 1).

Supplementary data related to this article can be found online at <http://dx.doi.org/10.1016/j.math.2016.02.007>.

## 2.2. Examination

At the physical examination one month after the second episode of the symptoms, the patient's pain was 3/10, and he presented with 28% on the Oswestry Disability Index (ODI) (Coelho et al., 2008). He was only working part-time at this stage. The patient was not afraid of bending over or sitting, but he was not confident in his left lower limb while walking because he felt his thigh was tense. He said that this lack of confidence was present even when he was with mild pain between the onset of the symptoms and the recent flare-up. For the Fear-Avoidance Beliefs Questionnaire (FABQ), the physical activity dimension was 27 points, and the work dimension was 29 points (de Souza et al., 2008). He was low risk according to the Start Back Screening Tool (Pilz et al., 2014).

The patient was asked to show the movement or tasks that reproduced the symptoms. He said that the main problem was the lack of confidence and stiffness in his left lower extremity when walking and climbing stairs. He reported stiffness and pain on the left side of the low back while in rotation of the spine, such as when cleaning himself after elimination and when washing his back during a shower. He also reported that he felt an increase in pain when he had to run to cross a street. Active flexion, extension, and neutral side bending were pain-free with full ROM. When passive ROM was tested in the side lying position, the patient presented a hypo-mobile lower lumbar in rotation. Palpation of the lumbar erector spinal muscles at L4 and L5 showed muscle tension on the left side. A lack of pelvic and thorax rotation as well as upper limb movements was noted during walking (Video 2). While climbing the step of a ladder, it was possible to observe an avoidant behaviour associated with the weight loading on the left lower limb. The patient abducted the upper limb to recover the balance (Fig. 3 and Video 3).

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The slump, straight leg raise, and prone knee flexion were all negative, and there were no neurological signs.

## 2.3. Intervention

Management of this patient was based on three closely related elements: maladaptive cognitive, functional and movement, as well as lifestyle behaviours, in an integrated manner. The objective of the cognitive intervention was to change the patient's belief that the surgery would be the only way to treat the cause of the problem. Reflective questioning was used to engage the patient in thinking through his ideas and to be able to determine the validity of his beliefs about the problem (Moran, 1998). The fact that there is a very high prevalence of degenerative disc disease in asymptomatic people and that the presence of a narrowing disc space did not predict LBP were mentioned.

Since the patient presented with a functional avoidant behaviour associated with the weight bearing in the left lower limb, he was exposed to lunge squat exercises focussing the loading in the left lower limb (Fig. 4, Video 4). The patient was asked to relax the abdominal wall and breathe. Also, he was encouraged to trust in his left lower extremity. After a set of 10 repetitions, he was tested again in the ladder and he started to present a different behaviour with more confidence in the left lower limb and a more relaxed

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