Editorial

Can Interventional Physiatry Overrule Conventional Physiatry?

Over last one decade there is a boom of Interventional Physiatry all over India. Specially the younger generation of Indian Physiatry community is showing tremendous inclination towards different types of interventions either blind or guided (USG/ C arm etc) procedures in different centres of PMR or different workshops during CME or conferences. This is very healthy, specific bold approach to practise the subject. The question is that "Are we neglecting the strength of conventional approach at the same time?"

From the very beginning the approach of Physiatry is primarily based on team work. We have plenty of non-pharmacological weapons in the armamentarium of PMR to tackle different clinical impairments. Those are our strength not weaknesses of our subject. Can we mingle up the other modes of treatment options with interventions?

Spinal pain due to PIVD is one of the most common conditions in consideration for an interventional Physiatrist. But as per different literature any decision regarding intervention should not be taken before practising Mackenzie's principle for at least forty-eight hours apart from the red flag signs. Not only that but also intervention has no role in mild pain or moderate pain of PIVD who are maintaining their ADL. If we want to treat spondylosis or spondylolisthesis then we cannot ignore the role of braces, flexion exercises, hamstring stretching exercise until today. Is there any scope of intervention in management of most common aetiology of non-inflammatory LBP like lumbosacral strain in younger patients? Even there is some role of conservative care in facet arthropathy or spinal canal stenosis etc. As per the evidences nobody can deny the role of exercise therapy in spinal pain remission and prevention of recurrence. Most importantly restoration of normal biomechanics by postural care is the key element to manage spinal pain.

If we consider the regional pain management then also interventions cannot defy conservative care. Simple practice of exercise therapy, orthoses and workstation modification can actually eliminate lots of local infiltrations in tennis or Golfer's elbow. Modifications of workstation and posture care are the key elements in management of any cumulative trauma disorder. Actually most of the non-inflammatory joint pain can actually better dealt by different modalities and pharmacological means. Is there any scope of intervention in knee pain due to patellofemoral joint pain syndrome (most common aetiology of anterior knee pain), soft tissue injuries like ACL, PCL, menisci injuries not amicable by surgery.

Lastly the decision regarding interventions like chemoneurolysis of botulinum toxin block should not be undertaken before a proper trial of orthoses, antispaticity exercise therapy and medications. Not only that but also the role of tone inhibiting orthoses and exercises cannot be ignored after a block.

Hence we should not underestimate the strength of conservative care like posture modification, orthoses, modalities or exercise therapy. Lots of other specialists are doing similar types of interventions. If we can mix up those procedures with our appropriate modalities the much superior results may be achievable. Timely appropriate intervention is much specific treatment option. So interventional Physiatry cannot overrule conventional approach but both are complementary to each other.

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