DI and the Physiotherapist

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Issues for Physiotherapists

- PTs need a solid understanding of what imaging contributes to our patient care.
- We should understand when to order and more importantly **when not** to order.
- Pts should have a general understanding of what are the strengths and weaknesses of each of modalities and what they image best.

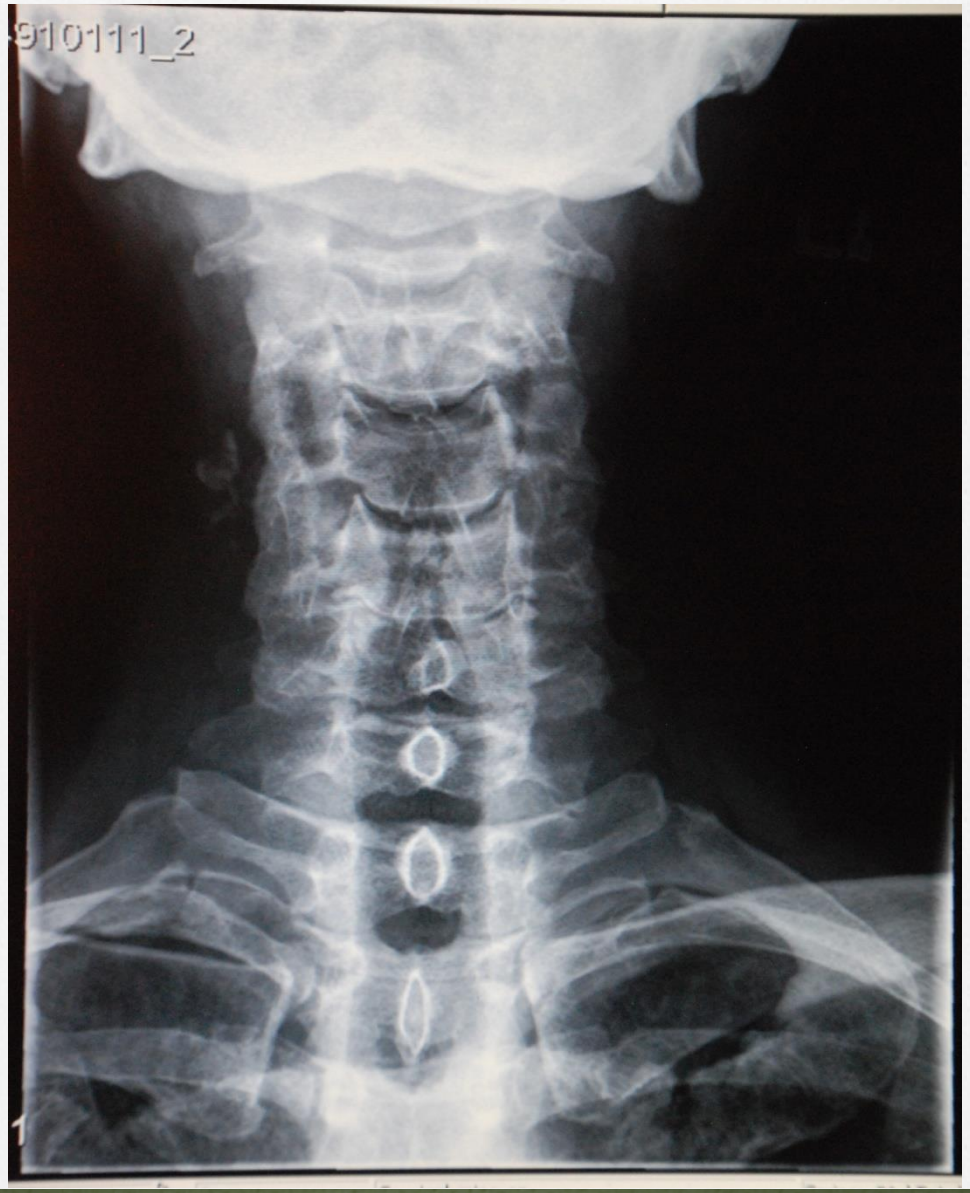
- Patients are anxious about getting imaging and judge their care based on whether they have had imaging or not.
- Legal implications.
- Many PTs work in private settings and are primary care givers.
- Some of us are in work environments that provide us with the time needed to adequately explain to patients the appropriate use of DI and set their minds at ease.

Specific Needs of PTs

- We have an additional need from DI and one that is often not met with solely reading the report.
- Knowledge of anatomical anomalies is important to manual therapists.
  - E.g. we can feel a cervical rib or a sacralization of a lumbar vertebra.
  - These are variations of normal and are often not reported.
  - Without knowing it is there we could think it was a hypomobility and potentially part of the patient's mechanical dysfunction.

Specific Needs of PTs

- This could prompt a PT to try an mobilize or manipulate it.
- It is not enough for a PT to read the report. They should view the films.
- In this case the image (typically a plain film) is taken to rule out barriers to treatment.
- Conversely too much information on a report causes undue angst in patients.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- “by all means take and X-ray but for God-s sake don’t look at it”

- We often want DI (plain films) to rule out contributors to LBP . Eg hips)

Simple First

- I have also had occasion where I requested information from the GP and never got it so recommended advanced imaging/investigation for a hip.
- A locum realized that a plain film had never been taken and ordered one. It showed significant OA and the diagnosis was complete and needed no further investigation.