Mckenzie Institute reply to: Gifford's editorial in PPA News 14, December 2002.

The following communications and article/response was published in the Mckenzie Institute UK Newsletter Vol 11 No 3 2003
It was also reproduced in full in PPA News 15.

Fear of Flexion – the debate, innocent or guilty?

Credentialled therapist Peter Ward contacted me in October 2002 to inform me that he had entered into an e-mail debate with Louis Gifford regarding an article that Louis had written for the Spring 2002 edition of the 'In Touch' magazine for OCPPP members. The article 'Perspectives on the biopsychosocial model – part 2: The shopping basket approach' had some comments regarding the McKenzie approach. These have been reproduced below (Ed):

'….but what if a back pain patient was told never to bend - like many so often are in the early stages of management. Fine to suggest care with some forms of bending to start out in the early stages perhaps, but surely bending confidence should be restored in a graded way at some stage? It is my belief that around 20 years of propaganda based on the disc derangement model and the concept of centralisation of pain relating to dubious biomechanical models for back pain has led to an unprecedented therapist fear of flexion that is passed on to patients (nice research project for someone!)….'

The e-mail correspondence between Peter and Louis follows below:

Dear Louis,

Regarding your recent In Touch articles on the biopsychosocial model, there was lots of useful information on pain mechanisms, & how to apply pain science in our treatments. There is one point however that I wish to comment on. You criticise the McKenzie system for producing a fear of flexion in therapists and patients.

Going back 10 years and beyond, the way in which physiotherapists generally gave information to patients with LBP could produce fear & anxiety (doctors even more so). I believe that it is now generally recognised by those giving training in the McKenzie method that the way we give information to patients is crucial if fear of activity is to be avoided.

So why is there such a strong perception that the McKenzie method produces fear of flexion? How justified is that perception? You contrast McKenzie extension exercises with Williams flexion exercises and imply that they are opposite sides of the same coin. I believe that the comparison is a poor one, for 2 reasons:-

(i) The Williams principle, as I understand it, comprises flexion alone. The McKenzie approach is to move the patient in the direction indicated by assessment. For those patients who show a directional preference (not all do, obviously), around 65-70% require extension initially. The rest need moving into flexion or other directions.
(ii)Under the McKenzie system, all patients who present with acute LBP are given a programme of flexion exercises as part of their overall management, including those who begin with extension exercises.

In his 1981 book, McKenzie states that problems frequently arise from our failure to restore full function following acute LBP, and we must explain to the patient that he may resume all the activities he used to and enjoys doing, including activities involving bending and lifting. A full programme of flexion exercises is a vital part of the process of restoring full function and confidence in bending following acute LBP, yet they are frequently omitted by therapists claiming to have given McKenzie treatments.

Problems certainly arise when the McKenzie or any other treatment principle is applied incompetently or inappropriately, but that is hardly surprising. However, if patients are treated competently using McKenzie principles, particularly combined with an understanding of psychosocial issues, there is no reason that they should develop a fear of flexion.

So, when other physios ask my advice on improving their skills in treating back pain, I shall continue to give the following advice:-

1) Do the Mckenzie courses for a simple patient-empowering system for dealing with mechanical pain.
2) Do Louis Gifford's courses for an understanding of pain physiology, of the context of nociceptive pain and pain mechanisms generally, and of the importance of psychosocial influences on pain and our treatments &
3) Join the PPA.

Peter Ward, Superintendent Physiotherapist, Tameside General Hospital.

Dear Peter,
Thanks for your comments! I might bring the topic up in the next PPA news editorial - as it is an area that interests me. We could then start a debate going - what do you think? Perhaps I could write my editorial - pass it to you for your comments and print your comments. In the mean time, could you tell me how the Mckenzie Institute currently explains the centralisation phenomenon and/or what it means - in relation to treatment as well as any pathology.

Louis.

Dear Louis,

Thanks for your reply. My interest in pain physiology and the psychology of pain and disability have grown since doing The Dynamic Nervous System in 1996. However, my experience of using the Mckenzie system has remained positive. I also think it would be interesting to debate these ideas. My view on the centralisation phenomenon is - The exact mechanism is uncertain. However there is some

evidence for a mechanical cause and effect relationship between disc pathology and centralisation/peripheralisation. (see Donelson et al study: Spine vol.22 No.10).

Whatever the exact mechanism is, the key clinical significance of centralisation is its value as a prognostic indicator, for which some evidence has been published (see Werneke studies: Spine vol. 24 No. 7 and Spine vol.26 No. 7).

Although the centralisation phenomenon linked with the Mckenzie concept appears to have a mechanical basis, obviously fluctuations in limb symptoms can have other causes not linked with mechanical changes, particularly variations in sensitisation and facilitation. It is important clinically to recognise the difference. This can be illustrated by two examples:-

Patient A has recovering back and leg pain, which has improved with extension exercises. Flexion exercises are cautiously introduced, and produce a return of leg pain, and also a loss of extension range plus increased pain on extension. In this case something undesirable is happening mechanically. Flexion would be postponed and retested periodically. Once it can be performed without producing a painful block to extension, it can be introduced and gradually progressed.

Patient B has recovering back and leg pain also helped by extension exercises. Flexion exercises are introduced and, similarly, produce leg pain. However, retesting shows no loss of extension following flexion. The key point is that the patient is mechanically no worse. The mechanism is probably neurogenic and linked with sensitive nerve tissue. This patient needs to be gradually exposed to flexion in order to reduce the sensitivity to that movement. (This was a demonstration patient on a McKenzie course here. The above illustrates how their problem was described on the course and how they were treated.)

What I'm saying is that the results of repeated movement testing, and the centralisation/peripheralisation phenomenon can be used as analysis tools, but it is important to interpret their significance in conjunction with all other clinical information, and an understanding of pain mechanisms and psychosocial factors.

I hope the above helps to answer your questions.

Peter.

Dear Peter,

Thanks for your reply and the articles. I will review them all before doing the editorial and will get back to you when I've done it.

Louis

Subsequent to this exchange Louis published a further editorial in the *Physiotherapy Pain Association Newsletter* to which Peter was unable to reply because he was sent the material too late. Peter has been dealing with this debate in an excellent manner. The UK faculty would also like to make its comments known, especially as any response that is published in PPA will not be available for months.