PRACTICE POINTS

Nurture your nomenclature

Putting focus on clinical terminologies BY DON DILLON

A decade ago, I reviewed the International Classification of Diseases (ICD) in preparation for dramatic changes in submitting auto insurance claims. I recall thinking how limited the list of conditions is in relation to soft-tissue dysfunction. There were codes for strains and sprains, headaches, fractures and neuropathies. However, specific soft-tissue states identifying fascial densification, myofascial trigger points (myofascial anything for that matter), or regressive states of muscle tension and texture were nowhere to be found.

It occurred to me that a language defining dysfunctions frequently treated by the perceptive palpations of massage therapists was grossly underrepresented. Lacking such nomenclature may impair our ability to identify the moment-by-moment state-changes in the soft tissues.

I hope to engage practitioners in thinking about professional nomenclature. Perhaps we can stimulate practitioners to better qualify what they find under their hands, contribute to their soft-tissue assessments and outcome measures, and improve their ability to conceptualize soft-tissue state-changes. Perhaps we may contribute to the profession's research and knowledge transfer as we develop and learn to speak the same language.

In the April/May 1995 issue of *Journal of Soft Tissue Manipulation*, Rob MacDonald reported on a muscle dysfunction classification by Dr. Hans Kraus. Kraus identified four categories of muscle dysfunction syndromes: muscle tension, muscle spasm/strain, myofascial trigger points and muscle deficiency (described as agonist/antagonist muscle imbalance). In effect, Kraus moved the massage conversation beyond "increased circulation" and "decreased muscle tension" to conceptualize and classify somatic dysfunctional complexes, normally not articulated in a physician's diagnosis.

From the International Classification of Diseases (ICD-10 – Chapter XIII Diseases of the musculoskeletal and connective tissues), I found the terms: myositis, muscle strain, myalgia, fibromyositis, rheumatism, tendinitis, adhesive capsulitis, bursitis, and traumatic ischaemia of muscle (compartment syndrome). While readers will be familiar with many of these terms, there may be a host of additional soft-tissue states not referenced.

Heinrich Reckeweg, a homeopathic practitioner, defined stages of progressive illness for the various organ systems, a theory he called "homotoxicosis." Particular to musculoskeletal pathology, he outlines the progression – from early to late stages – as myalgia, myositis and myogelosis. If not addressed, the muscle's histologic state progresses to myositis ossificans (think bone spurs/calcification of soft-tissues under constant duress) and muscular asthenia. In late stages, Reckeweg pronounces mitochondrial myopathy, dermatomyositis, muscular atrophy/dystrophy, and myosarcoma as progressive outcomes of a downward spiral.

Certainly, more histological evidence is required to confirm these pathologic states, but the language framework Reckeweg presents may be helpful in nomenclature development.

What about the language we use when speaking to patients? Greg Lehman cautions against raising a person's pain sensitivity with ill-formed explanations. "You put your back out", "your spine is unstable," "damaged" and "adhesions" may lead to catastrophizing, kinesiophobia, fear avoidance and poor self-efficacy in attempting to recover from pain. Lehman explains the poor correlation between structural damage and medical imagery results with the pain a person experiences. Pain is mediated by expectations, learning, context, beliefs, poor sleep or anxiety. Lehman admonishes, in addressing a person's questions about pain, we should apply a bio-psycho-social model. Lehman's excellent reference Recovery Strategies: Pain Guidebook outlines key messages and metaphors to help patients re-conceptualize pain, re-habituate movement and build resilience in recovery.

In Carla-Krystin Andrade's book, Outcome-Based Massage, she goes beyond exclusively targeting rehabilitative functional outcomes to recognize wellness objectives. These include: improved energy and sleep, better social functioning and family relationships, a sense of well-being, improved mood, relaxation and coping skills, mindfulness and greater life satisfaction, positive attitude and empathy towards others. When engaging patients, colleagues and those outside our profession, we can use these terms to expand the applications and outcomes of massage therapy treatment plans.

Lacking nomenclature may impair our ability to identify state-changes in the soft tissues.

What nomenclature shapes and defines your understanding of the soft-tissue state changes you're inducing? What words do you use to set up patient expectations and treatment plan objectives? As the science progresses, our nomenclature must too.

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