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Is Primary Care Taking Full Advantage of Physical Therapy?

Announcer:
Welcome to ReachMD. You're listening to Everyday Family Medicine with Dr. Jennifer Caudle.

Dr. Caudle:
Whether it's to reduce pain, improve mobility, or better manage a condition, physical therapy is a viable option for many of our patients, but are we taking full advantage of it in practice? According to the Journal of General Internal Medicine, primary care physician referral rates to physical therapists have dropped 50% from 2003 to 2014. So, how can we better collaborate with physical therapists to reverse this trend?

Welcome to Everyday Family Medicine on ReachMD. I am your host, Dr. Jennifer Caudle, and joining me is Catherine Apicella, a physical therapist who will be sharing insights from her own experience and some strategies to help physicians partner with physical therapists.

So, Catherine, welcome to the program.

Catherine:
Thanks for having me here.

Dr. Caudle:
Absolutely. So I wanted to start off a little bit by talking about your story. Can you tell us a little bit about your background and what made you become interested in physical therapy?

Catherine:
So, for a long time, as long as I can remember, I wanted to work in healthcare, I wanted to help people and kind of... I wasn't sure what I wanted to do until I took an anatomy class in college, and I fell in love with it. And then I realized I want to teach people how to move better, I want to help educate people, and I felt like the best way to do that was to be a physical therapist, get the most one-on-one time. So, yeah, I started, actually, my career in pediatrics.

Dr. Caudle:
Okay.

Catherine:
So I worked in kind of all ranges—

Dr. Caudle:
Interesting, yeah.

Catherine:
—acute care, home care, schools, and then I also did acute care with adults in the hospital setting. Aquatics I've also done and then some outpatient. And then I took a little time off, worked part-time when I had my kids and kind of came back into it, and from having my children, I became interested in pelvic floor physical therapy. I also had a colleague who was a pelvic floor PT who said, "I think you should really look at this training. I think you would really love it based on what you're into and your..."

Dr. Caudle:
Yeah.

Catherine:
And I said, “All right, I’ll take it. I’ll see what happens.” I took the course, the initial course, and loved it, and so since then I’ve been working in pelvic floor PT.

Dr. Caudle:
Right. Oh, that’s so interesting, and it’s also interesting to hear all the different environments that you worked in, so you really have experience from children to adults, inpatient, outpatient, schools even you mentioned, so that’s really nice. And I guess, in your experience, what typically brings patients to you? And more specifically, what symptoms and conditions do they present with?

Catherine:
Yeah, so most commonly... The field that I work with in pelvic floor physical therapy, most commonly—the most common diagnoses are urinary incontinence usually. There’s different types of urinary incontinence, but stress urinary incontinence, leakage with coughing, sneezing, or urge incontinence where you have leakage with a really strong urge. Overactive bladder is a combination of basically a bladder that is too active and you have urgency, frequency, leakage, things like that, but we also get lots of referrals for prenatal and postpartum women—

Dr. Caudle:
Oh, okay.

Catherine:
—diastasis recti, which is kind of separation of the rectus abdominis—

Dr. Caudle:
Yes, interesting.

Catherine:
—pelvic pain, different types of pelvic pain, constipation, fecal incontinence, pelvic organ prolapse of various stages and varieties; and then just even as far as hip pain, back pain, that sometimes might have a pelvic component possibly or maybe that hasn’t responded to typical therapy, and maybe if we address the pelvic floor, that might be an issue. So that’s kind of a brief range. I know I’m missing a few things.

Dr. Caudle:
Sure, but it gives us an idea of some of the options and possibilities, absolutely.

Catherine:
Yes. Oh, and sexual dysfunction.

Dr. Caudle:
Sexual dysfunction.

Catherine:
Yes, pain with intercourse, even—I’m sorry—erectile dysfunction.

Dr. Caudle:
Oh, interesting.

Catherine:
Yeah, pain with orgasm.

Dr. Caudle:
That’s really good to know.

Catherine:
Pain with ejaculation, yeah, things like that.

Dr. Caudle:
Absolutely. Well, and this brings me to another question. I’m a primary care physician. I’m a family physician. And do most physical therapy facilities offer pelvic floor physical therapy? Is your specialty something that’s difficult to find? This is just for those of us who are watching and saying, “Oh my gosh, either I need that or I need to refer my patients to this type of therapy.”

Catherine:
Right. Yeah, it’s not as common as... I mean, orthopedic, general orthopedic PT is really widespread. It’s not... It’s getting there.

It's gaining in awareness, and more people are interested in kind of pursuing this field, but it's still very uncommon. It's more common in kind of the metro areas where you have the big health centers. All the major health centers usually have a good pelvic floor PT department within them, but beyond that, kind of out in the outskirts it's a little—it's much harder to find.

Dr. Caudle:
Okay, all right, and that's good to know as well. So you talked to us a little bit about some of the range of conditions that you may work with or symptoms that patients may present to you with. Once you work with a patient, how do you really collaborate with that patient's primary care physician to really ensure they get the best outcome, and what strategies really do you think are most effective?

Catherine:
So, what we like to do when they first come in, we definitely ask them who their referring physician is. Sometimes it is their family practice. Sometimes it's their OB/GYN or urologist, pain specialist.

We always try to get—ask them, "Are there any other doctors you'd like us to keep in the loop about what's going on?" And then we send our evaluation report to those doctors. And what we like to do is, every few weeks we like to send a brief 2- to 3-line case update to the physician to just let them know basically, "Patient X is improving in XYZ. We're still working on XYZ. We'll keep you updated."

Dr. Caudle:
Sure.

Catherine:
And then we'll also... We also ask them when they have their follow-up visits because we also like to make sure... Sometimes those messages, if they are faxed over, sometimes they get lost.

Dr. Caudle:
Yes. Yes, they do.

Catherine:
Yeah, so when they actually go in to see you face-to-face, we like to know that, and then give them a printout of their report that they can then hand to the physician.

Dr. Caudle:
Oh, that's nice.

Catherine:
And we can make sure that they... And sometimes we occasionally have had physicians kind of send the note back just with a little bit of writing on it or something—

Dr. Caudle:
Sure.

Catherine:
—because we tend to... We try to go and see some physicians and do marketing lunches, things like that, just to kind of help bridge that relationship, and that's one of the things we often hear is, "Once we send patients out, we don't know what happens to them."

Dr. Caudle:
Well, and I love that idea of handing the patient information to bring to us. As a family doctor… I was in the office yesterday, for example, and you are seeing patients for whatever is on your list and maybe whatever they tell you about, but if they have been in physical therapy for 6 to 8 weeks for something and it doesn't come up, it kind of may get pushed to the wayside until it's brought up.

Catherine:
Yes.

Dr. Caudle:
So I really like that idea of sort of kind of reinstituting almost… It's like a check-in too. It gives us a chance to say, "How are things going?" and, "What's working for you?"

Catherine:
Yes.

Dr. Caudle:
I really like that. So you talked a little bit about how your practice works with physicians and helps to bridge that communication gap and things like that and also letting physicians and clinicians know about the services you offer, because we know that that's a big thing. What specific symptoms or diseases should we be on the lookout for to refer these patients to physical therapists like yourselves? What would you say?

Catherine:
Again, for pelvic floor PT, any type of leakage—urinary, fecal, and type of—or urinary frequency, feeling "I've just been going to the bathroom an awful lot; I'm not sure why;" or that urgency. The feeling, even a feeling of having a UTI and being clear for it—

Dr. Caudle:
Right.

Catherine:
—that's a common manifestation of pelvic floor dysfunction is the symptoms of a UTI without actually having one, so we can help with that. Endometriosis is a common one.

Dr. Caudle:
Interesting.

Catherine:
Again, we don't treat the endometriosis, but we can treat the pain and the additional...

Dr. Caudle:
Effects or sort of the sequelae—

Catherine:
Yes.

Dr. Caudle:
—or things that happen along with the endometriosis symptoms, I'm guessing.

Catherine:
Yes, exactly.

Dr. Caudle:
That's so interesting.

Catherine:
Exactly. Yeah, a variety of pelvic pain diagnoses. And a lot of times, I mean, the imaging and the medical workup is really important to know what is the back... You know, pelvic pain can have many, many different, you know...

Dr. Caudle:
Right, right.

Catherine:
But in the meantime, even while they're undergoing a workup, they can come to PT; they can work on—

Dr. Caudle:
That's a good idea.

Catherine:
—helping to reduce tension and pain and just become more aware of what's going on with their bodies.

Dr. Caudle:
Yeah.

Catherine:
Feeling of pelvic pressure and heaviness, which can be a symptom of prolapse of organs, which again could be an issue of weakness of the pelvic floor and the core, impaired strategies of being able to manage your pressure as you're doing things in your life… Again, pain with intercourse is a big one. I mean I've heard some really unfortunate stories of young women being told, "Well, it will get better. Just drink some wine." And they are just feeling like it's a normal thing and there must be something wrong with them because they can't

tolerate it, and so they just keep pushing through, or they cry during their... I think that's another thing. Anybody who cries during an internal pelvic floor—GYN exam or an internal exam, anybody who it's so painful, we can help with that.

Dr. Caudle:
That's a really... That's really insightful and very helpful. As a primary care physician, I do Pap smears in the office.

Catherine:
Sure, yeah.

Dr. Caudle:
Of course, my OB/GYN colleagues, this is what they do all the time, but I think for maybe those of us who are not OB, I think these are maybe signs and symptoms that we need to be alerted to and saying, "Hey, maybe there's more that I can do as a physician than what initially comes to mind," so it's very insightful, very insightful. I'm like, "Go on. Go on. Go on. Tell me more."

(Laughter)

Dr. Caudle:
It's really helpful. I think this is good for broadening our minds, also. So I can't believe we've kind of come to the end of the interview. I want to know, Catherine, before we end, are there any other takeaways that you'd like to leave our audience with or suggestions or anything at all?

Catherine:
Well, I think also, because of where I work—it's not just a pelvic floor practice or orthopedic practice—but we see a lot of different conditions, and I think that it's good, especially as a family practice physician, to know that PT also can treat a variety of conditions, such as headaches, concussion, vertigo and balance issues, TMJ—temporal mandibular joint disorder—carpal tunnel, neuropathy. Different types of neuropathy can be helped with PT as well, of course back pain of various types of origins—

Dr. Caudle:
Right.

Catherine:
—and that we don't need... Again, while imaging can be helpful, we don't need... A patient doesn't need to have imaging done before coming to PT. A lot of times we can... If they have pain of one variety or another or dysfunction of one variety or another, they can come to PT. We can address the issue. And sometimes the imaging can cloud the issue a little bit or kind of bias the issue a little bit, whereas... Because there has been studies that have shown that what's shown on imaging is not necessarily correlated with symptomatology and that dysfunction that can be shown on imaging can be due to just normal process of aging.

Dr. Caudle:
Interesting.

Catherine:
I mean, there can be correlations, absolutely.

But they have shown that people can be in a lot of pain, not necessarily have much on imaging, or vice versa.

Dr. Caudle:
Right, that's true.

Catherine:
People can have images that look terrible and...

Dr. Caudle:
They're fine.

Catherine:
Exactly.

Dr. Caudle:
Right.

Catherine:
Exactly.

Dr. Caudle:
That's true. That's true.

Catherine:
So I think that part, too, is helping people become empowered and realize that you're sending them to PT to see. And again, as PTs, we also work to differentially diagnose. If there's something that we're not sure about or we think, "Do you know what? I think maybe you should—"

Dr. Caudle:
Right.

Catherine:
"—before we go any further..." I mean, that's part of what we do, so people should feel comfortable that they're going somewhere and they're going to be treated the way they should be treated.

Dr. Caudle:
Right, and taken care of, which is good.

Catherine:
Yes.

Dr. Caudle:
This is excellent. Well, Catherine, thank you so much. This was so helpful. Thank you so much for joining us today.

Catherine:
Thank you so much for having me. It's been a pleasure.

Dr. Caudle:
I'm Dr. Jennifer Caudle, and to access this episode and others in the series, please visit ReachMD.com where you can Be Part of the Knowledge. Thank you for listening.

Announcer:
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