Pain

To the Editor:

When I submitted the manuscripts about pain for the January 1980 issue of PHYSICAL THERAPY, I pointed out how rapidly information was accumulating in the area of neurophysiology as it related to pain and if it took a year to publish a review, it would be out-of-date before it appeared in print. That was not the prediction of a pessimist, but of a realist. In fact, the prediction has come true. I have before me 64 reprints that I have received since submitting the manuscript. This number does not include symposia, books, or review articles!

If your readers are interested in “keeping up” on this important subject, they may find the following references useful.
Pain terms: A list with definitions and notes on usage. (Recommended by the IASP subcommittee on taxonomy.) Pain 6:249-252, 1979

I can only encourage therapists to make an attempt to keep abreast of this fast-moving area of neurophysiological research. Few other subjects can be more pertinent or relevant to their patient’s comfort or progress.

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Effects of Cold

To the Editor:

I would like to offer some questions and comments concerning the article, “Effects of Cold Submersion on Intramuscular Temperature of the Gastrocnemius Muscle,” by Johnson and associates (Phys Ther 59: 1238-1242, 1979).

The article stated that oral temperature of the subjects was monitored and I must assume that it did not change because this was not stated. The ambient temperature was not given and I assume that it was from 68°F to 73.4°F (20°C-23°C). Was the contralateral leg covered or not? Probably not. I submit that anyone lying uncovered and inactive in a room 13°C to 16°C cooler than body temperature for a period of five hours would tend to cool. The core temperature would tend to be maintained at the expense of peripheral circulation. Initial cooling in the contralateral leg during the application of cold water to the ipsilateral leg is rather an acceleration of the physiological changes to maintain the core temperature than a reflex vasoconstriction from the cold application. It would be interesting to know the temperature of the gastrocnemius muscle of a control subject with the leg uncovered at the same ambient temperature, after five hours of inactivity without the application of cold to either leg.

You may wish to repeat the experiment while maintaining the core temperature with application of infrared heat or diathermy while cold is being applied to the ipsilateral leg and see what changes take place. I rather expect that the contralateral leg will cool even less and may even warm a bit.

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The Author Responds:

I appreciate the opportunity to respond to Mr. DonTigny’s letter concerning our article.

Oral temperatures did not alter significantly nor was it expected they would. The ambient temperature in the laboratory was maintained at 78°F ± 1° (25.7°C). This would produce a temperature gradient of 7.6°C if normal skin temperature is considered to be approximately 33.3°C. This level was maintained and monitored closely because it was apparent to the authors that ambient temperatures could affect the results.

The question, however, is not whether the intramuscular temperature of an inactive person will decrease during the five-hour test session, as submitted by Mr. DonTigny. There is literature addressing this matter and the very issue that Mr. DonTigny makes is discussed by us in the second paragraph of our Discussion section (p 1241). I would also like to refer...
interested readers to another reference on this matter by Oliver and associates in Archives of Physical Medicine and Rehabilitation 60:126–129, 1979. The question raised by the Oliver study concerns the significant decrease of intramuscular temperature of the contralateral leg during a 30-minute treatment period. Also, Mr. DonTigny’s suggestion that this change is probably due to “physiological changes” is the same conclusion drawn by us (last paragraph, p 1242).

On the suggestion for further research, I see no reason to maintain core temperature with the use of infrared heat or diathermy since previous research has clearly indicated that cold application to the extremities, as used in our study, will not significantly affect core temperature.

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Question About HR 3990

To the Editor:

The legislative proposal known as HR 3990 now before the House Ways and Means Committee is supposedly designed to bring Medicare benefits for physical therapy services more in line with present-day needs of the patient. Although this may indeed be one result, there are aspects of the legislation that now only perpetuate current inadequacies but also can only be viewed as discriminatory toward a particular population of physical therapists—namely the independent practitioners.

As proposed, the legislation would remove virtually all restraints from extended care and home health agency physical therapy services (unlimited visits, no deductible, no hospitalization requirement), while allowing for only a token increase (from $100 to $500 per calendar year) for independent practitioner-provided services.

On the one hand, the federal government and the patient may be spared unnecessary hospital costs. On the other hand, they will both suffer unnecessary financial burden because the cost of home health agency care is consistently higher than hospital care (as much as 100% in Washington, DC) and is often inadequate or unavailable. The patient may be forced to either absorb the cost of treatment or travel to a hospital setting, again at higher cost, or be admitted to an extended care facility, once again at higher cost.

Worse yet, the patient may simply go without care. Why then is the APTA supporting HR 3990?

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Reply:

HR 3990 was not designed to bring Medicare benefits for physical therapy services more in line with present-day needs of the patient. HR 3990 is an omnibus Medicare amendment bill that, at this writing, has passed the House Ways and Means Committee and awaits action by the full House of Representatives. HR 3990 originated as a bill by Congressman Rangel (D-NY), the chairman of the Ways and Means Health Subcommittee. Chairman Rangel, probably the most influential House member on health matters, is very interested in expanding home health agency services and included in HR 3990 the home health agency provisions mentioned in Mr. Sherwood’s letter. The Health Subcommittee was faced with approximately 80 separate bills to amend the Medicare laws, including HR 4626, Congressman James Shannon’s (D-MA) bill developed in collaboration with APTA. The Health Subcommittee then “marked-up” an omnibus bill by choosing a few of these amendments and incorporating them into the chairman’s HR 3990.

There are several provisions of HR 3990 that the APTA might not support if they were offered separately. That is not how Congress works, however. Congress works by taking many proposals on an issue and sifting them into one bill, which may or may not then become law. Withdrawal of our support of the bill would probably result in the removal of the increase in physical therapy reimbursement, but it would not prevent the liberalization of the home health agency requirements.

I am sorry that Mr. Sherwood believes that a 400 percent increase from $100 to $500 in reimbursement for physical therapy services is “only a token increase.” Later in the letter, a 100 percent difference in other amounts seems to disturb him a great deal. The increase from $100 to $500 will help many patients in the United States. It will also help a great many physical therapists who are private practitioners. As I explained in the December Progress Report, this increase, and accompanying legislative history language, is the best result that we can expect at this time.

EDWARD H. BAXTER
APTA Governmental Relations Director