Abbreviations for Use in Osteopathic Case Notes

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Abstract

A list of standard abbreviations for terms used in osteopathic case history taking has been agreed upon and endorsed by the three Australian osteopathic teaching institutions.

Keywords: abbreviations, medical history taking

Introduction

It has been established that abbreviations used in osteopathic case history records by Australasian osteopathic teaching institutions vary widely.[1] This probably reflects an even greater variation used within the Australasian profession as a whole. This is likely to present difficulties when communicating patient details between osteopaths, for locums attempting to decipher case history notes, and researchers collating patient records.

It is hoped that if the osteopathic teaching institutions can agree and endorse a core list of abbreviations for case notes, graduating students as well as the profession as a whole may progressively adopt the list and help standardise our common language.

Methods

Step One

A list of terms and phrases believed by the author to be useful or in common use, along with a list of suggested abbreviations for the terms, was presented to either Heads of Course or Heads of Clinic in various osteopathic teaching institutions. Questionnaires were sent to the Royal Melbourne Institute of Technology, Melbourne (RMIT), Victoria University, Melbourne (VU), University of Western Sydney, Sydney (UWS), and UNITEC Institute of Technology, Auckland.

The list of suggested abbreviations was produced by the author by selecting those abbreviations that were currently in common use[1], or by selecting another that the author felt was more appropriate. Where either the term or the abbreviation was not in common use, the author included a note of explanation for the rationale of including such a term.

Respondents were asked to rank their level of support for each abbreviation by:

++	strong support
+	partial support
_	partial disagreement
_ _	strong disagreement

If the respondent was to disagree with an abbreviation or the inclusion of a term, they were asked to choose an alternative abbreviation or include a comment.

Step Two

The respondents were presented with the results of Step One, which included those abbreviations that had gained unanimous support, and for those that did not a list of alternative abbreviations offered by any respondent was included.

Respondents were asked to view the suggested and offered alternative abbreviations and indicate their preference. Additionally, they were asked whether they would accept the suggested abbreviation even if it were not their preference.

Step Three

The results of Step Two were presented to the respondents for final endorsement or veto. All abbreviations that had not gained unanimous consensus in the previous step were presented again with the alternative abbreviation preferred by a respondent. Respondents were asked if they were willing to adopt this preferred alternative. Segmental dysfunction nomenclature abbreviations were also presented for endorsement or veto.

Results

Step One

The author was advised that UNITEC could not assist with this project at this stage. All terms and abbreviations received either strong or partial support from all respondents. The abbreviations that gained only partial support are listed below (Table 1).

The following terms received unanimous endorsement: Low back pain, Left, Right, Sidebending, Increased, Decreased, Greater than, Lesser than, No apparent reason, Nothing abnormal detected, Headache, Range of motion, Intervertebral disc, Ligament, Zygapophyseal joint, Trigger point, Sternocleidomastoid, Trapezius, Quadratus lumborum, Shoulder, Differential diagnosis, Prognosis, High velocity low amplitude thrust, Muscle energy technique, Myofascial release, Counterstrain, General osteopathic treatment, Functional treatment.

Table 1: Step One: Abbreviations Without Full Agreement

STEP ONE: ABBREVIATIONS WITHOUT FULL AGREEMENT		
WORDS & PHRASES	**SUGGESTED ABBREV.**	**OFFERED ALTERNATIVES**
Lumbar spinal pain	LxP	
Sacral spinal pain	SxP	
Lumbosacral pain	LSP	L ≈◄ (pain represented by an arrowed serrated line)
Loin pain	loin P	
Gluteal pain	glut P	$L_{sp}P$ (an alternative, but not preferred)
Thoracic spinal pain	TxP	
Cervical spinal pain	CxP	
Flexion	flex	F or f
Extension	ext	E or e
Rotation	rot	R
External rotation	Ext rot	ExR ext rot
Internal rotation	Int rot	InR int rot
Abduction	Abd	Ab
Adduction	Add	Ad
Aggravate	Agg	↑↑
Relieve	Rel	↓
Motor or sensory	M/S	m/s
Motor vehicle accident	MVA	RTA
Sacroiliac	SI	SIJ
Cervical erector spinae	CES	CxES
Thoracic erector spinae	TES	TxES
Lumbar erector spinae	LES	LxES
Straight leg raise	SLR	SLRT
Diagnosis	Dx	Triangle with a dot
Articulation	Artic	Art
Cranial	CR	OCF Cran
Soft tissue technique	ST	STT DTM

Step Two

Nearly all of the suggested terms and abbreviations gained full endorsement from all osteopathic teaching institutions. The only abbreviations that did not were motor and sensory and Cranial (Table 2).

Table 2: Step Two: Abbreviations That Did Not Gain Unanimous Agreement

STEP TWO: ABBREVIATIONS THAT DID NOT GAIN UNANIMOUS AGREEMENT		
WORDS & PHRASES	**ORIGINALLY SUGGESTED ABBREV.**	**ALTERNATIVE PREFERRED BY RESPONDENT**
Cranial	CR	OCF
Motor or sensory	M/S	None

Step Three

A list of terms and abbreviations were endorsed by the three Australian osteopathic teaching institutions (Table 3). Abbreviations for segmental somatic dysfunction were also endorsed (Table 4).

Table 3: A List Of Abbreviations That Have Gained Endorsement From Australian Osteopathic Teaching Institutions

A LIST OF ABBREVIATIONS THAT HAVE GAINED ENDORSEMENT FROM AUSTRALIAN OSTEOPATHIC TEACHING INSTITUTIONS			
Words and phrases	**Abbrev**	**Words and phrases**	**Abbrev**
Lumbar spinal pain	LxP	Intervertebral disc	IVD
Sacral spinal pain	SxP	Ligament	lig
Lumbosacral pain	LSP	Zygapophyseal joint	Z jt
Loin pain	loin P	Sacroiliac	SI
Gluteal pain	glut P	Trigger point	TrP
Thoracic spinal pain	TxP		
Cervical spinal pain	CxP	Cervical erector spinae	CES
Low back pain	LBP	Thoracic erector spinae	TES
		Lumbar erector spinae	LES
Left	Ⓛ	Sternocleidomastoid	SCM
Right	Ⓡ	Trapezius	Trap
		Quadratus lumborum	QL
Flexion	flex		
Extension	ext	Shoulder	Sh
Rotation	rot	Straight leg raise	SLR
Sidebending	SB	Range of motion	ROM
External rotation	Ext rot		
Internal rotation	Int rot	Diagnosis	Dx
Abduction	Abd	Differential diagnosis	DDx
Adduction	Add	Prognosis	Prog
Increased	↑	Articulation	Artic
Decreased	↓	High velocity low	
Greater than	>	amplitude thrust	HVLA
Lesser than	<	Muscle energy technique	MET
Aggravate	agg	Myofascial release	MFR
Relieve	rel	Counterstrain	CS
No apparent reason	NAR	Cranial	OCF
Nothing abnormal detected	NAD	Soft tissue technique	ST
Headache	H/A	General osteopathic	
Motor vehicle accident	MVA	treatment	GOT
		Functional treatment	Funct

Table 4: Abbreviations for segmental dysfunction

SEGMENTAL DYSFUNCTION NOMENCLATURE ABBREVIATIONS
Either POSITIONAL
Eg: **L2 FRS_L** (where F = flexed, R = rotated, S = sidebent)
Or LIST MOTION RESTRICTIONS
Eg: **L2 ↓ ext, rot Ⓡ, SB Ⓡ**
(where ext = extension, rot = rotation, SB = sidebending)

Discussion

Agreement has been reached by all Australian osteopathic teaching institutions on a core list of terms and abbreviations to be used in osteopathic case histories. The author believed that a small list of core terms and abbreviations would be more useful than an exhaustive list. Such lists are never intended to remain static and should be added to and amended as the profession sees fit. It is hoped that regular updates of such lists will be published in the future.

When attempting to gain consensus on a standard list, it became clear that this was an opportunity not just to endorse those terms most commonly used, but to shape and improve osteopathic record keeping for the future. Respondents were asked what they would like to see, rather than what they most commonly used at the present.

To standardise abbreviation usage and adopt terms not currently used required a willingness to change what each institution was presently using. Happily, each of the osteopathic departments rose to the challenge.

The nomenclature and abbreviations for spinal pain are a case in point. Although LBP (low back pain) is widely used,[1] the author believed this term should be avoided or even abandoned due to its vagueness. LBP may mean lumbar, lumbosacral, sacral, gluteal, or loin pain; unless further defined we have no idea. The author advocated using the International Association for the Study of Pain (IASP) definitions[2] as follows:

> ***Lumbar Spinal Pain*** is pain perceived as arising anywhere within a region bounded superiorly by an imaginary transverse line through the tip of the last thoracic spinous process, inferiorly by an imaginary transverse line through the tip of the first sacral spinous process, and laterally by vertical lines tangential to the lateral borders of the lumbar erectores spinae.
>
> ***Sacral Spinal Pain*** is pain perceived as arising from anywhere with a region bounded superiorly by an imaginary transverse line through the tip of the first sacral spinous process, inferiorly by an imaginary transverse line through the posterior sacrococcygial joints, and laterally by imaginary lines passing through the posterior superior and posterior inferior iliac spines.
>
> ***Lumbosacral Pain*** is pain perceived as arising from a region encompassing or centred over the lower third of the lumbar region as described above and the upper third of the sacral region as described above.
>
> Lumbar spinal pain, sacral spinal pain, or lumbosacral pain, or any combinations thereof, legitimately constitute what colloquially might be referred to as "low back pain". These definitions explicitly locate the pain as perceived in the lumbar and/or sacral regions of the spine. In that regard, "back pain" does not refer to pain in the posterior thorax. That is more correctly referred to as thoracic spinal pain.
>
> What do not constitute low back pain are ***loin pain*** and ***gluteal pain***. Loin pain is pain perceived over the posterior region of the trunk but lateral to the erector spinae. Gluteal pain is pain in a sector centred on the greater trochanter and spanning from the posterior inferior iliac spine to the anterior superior iliac spine.[2]

The suggested abbreviation for “lumbar spine” was Lx, which was already in use within the profession. The commonly used L (the usual abbreviation for “lumbar” rather than “lumbar spine”) would not have been appropriate as LP (lumbar spinal pain) and TP (thoracic spinal pain) would have proved confusing. Abbreviations such as TxP could be prefaced with upper, mid or low to make it more specific.

The use of a serrated arrow or lightening bolt is commonly used to denote pain[1], and one of the respondents listed it as a preferred alternative to P in LxP. It was argued that the lightening bolt had the disadvantage of not being able to be used on computer notes (it is believed many osteopaths record episode titles on computer) and were likely to be drawn with great variation between osteopaths. The proposed and endorsed abbreviations are easy to read, can be used on computer notes and are likely to be recognisable beyond the Australian profession.

Many of the endorsed abbreviations already have wide acceptance according to the preliminary study[1]. Some of the treatment abbreviations (of which there had been poor consensus) have been adopted from the Glossary of Osteopathic Terminology of the American Association of Colleges of Osteopathic Medicine.[3] One exception is MET (muscle energy technique) which has become more commonly used in journals than the Glossary's ME. The abbreviation of OCF for Osteopathy in the Cranial Field was also preferred to the Glossary's CR.

The author chose several abbreviations that the previous study indicated were not in common use in the teaching institutions. TrP, rather than TP, is now commonly used in reference books[4] and journals as the abbreviation for (myofascial) trigger points, Z jt (zygapophyseal joint) appears to be gaining greater popularity and Sh (shoulder) is consistent with Dorland's Medical Abbreviation.[5]

The term motor and sensory was the only one in which agreement on a satisfactory abbreviation was not reached. It was felt by one of the respondents that M/S was too easily confused with musculoskeletal, and a satisfactory alternative was not found.

The previous study[1] indicated that segmental somatic dysfunction was abbreviated either as positional nomenclature or motion restriction nomenclature. The abbreviations for positional nomenclature endorsed in this study were consistent with the abbreviations used in most modern American osteopathic textbooks[6,7]. Where the nomenclature for segmental dysfunction involved listing motion restrictions, the abbreviations used were consistent with our endorsed list of abbreviations.

It must be stressed that capital letters should be reserved for the use of positional terminology only (such as F = flexed, E = extended, R = rotated, S = sidebent; note the past tense used with positional terms) and endorsed abbreviations should be used when listing motion loss. Capital letters should never be used when listing motion loss as it will create confusion and may be interpreted as the opposite of the intended notation.

Conclusion

Agreement has been reached by all Australian osteopathic teaching institutions on a core list of terms and abbreviations to be used in osteopathic case histories. Improvements to the common nomenclature for spinal pain should make osteopathic record keeping more accurate. This is an important step towards standardising and improving osteopathic record keeping in the Australian profession.

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