A physiatrist specializes in physical medicine and rehabilitation medicine. The aim of rehabilitation is to improve quality of life by maximizing function and minimizing the disability resulting from the underlying impairment or disease. Typically, the physiatrist works with a multidisciplinary team of allied health professionals. The team could include physiotherapists, occupational therapists, social workers, prosthetists, orthotists, dieticians, speech therapists, psychologists, and recreation therapists. Any person with an injury or disease affecting the musculoskeletal, neurological, or cardiorespiratory systems could benefit from the expertise of a physiatrist. Physiatrists work in the community, in general and specialized rehabilitation hospitals, and in rehabilitation units found in some acute care hospitals.

Some examples of when a referral to a physiatrist could be helpful:

1. Your patient needs a prosthesis.
Your patient has had a limb amputation (e.g., from vasculitis) and needs a prosthesis. It is preferable for the patient to be evaluated before the amputation. The physiatrist can also provide the prosthetic prescription and manage any complications of amputation and prosthetic issues (e.g., poor fit).

2. Your patient needs care after a stroke.
Your patient has had a stroke (e.g., related to systemic lupus erythematosus [SLE]) and needs follow up and ongoing care. The physiatrist can assess whether the patient may benefit from admission to a specialized stroke rehabilitation unit. Factors suggesting a poor functional outcome include the following: comorbid conditions, severe neurological deficit, inability to maintain an unsupported sitting posture, inability to retain information from day to day, bowel and bladder incontinence, and a poor score on a functional outcome measurement tool.

Rehabilitation and treatment for a stroke patient could include medications such as baclofen and botulinum injections for spasticity, physiotherapy, occupational therapy, provision of assistive devices and/or arrangement of home-care services. Treatment and prevention of stroke complications could include avoiding aspiration due to swallowing disorders, and therapies for depression, pain syndromes, pressure sores, thromboembolic disease, poor nutrition, and seizures.

Your patient has been in a motor vehicle accident and has had a traumatic brain injury (TBI) and you are wondering about treatment. Such patients can have complicated physical and cognitive deficits. Complications of head injury requiring treatment could include fractures, seizures, hypertension, cardiopulmonary disorders, endocrine dysfunction including derangement of anterior pituitary function, cranial nerve issues, sensory issues, heterotopic ossification, nutrition, and bowel and bladder issues. Neuropsychological evaluation may be helpful, especially if there are medicolegal issues.

4. Your patient has unexplained weakness.
Your patient has unexplained weakness and you are wondering about myositis. In this case, electrodiagnostic testing may be helpful. Electrodiagnostic testing, performed by physiatrists, neurologists, and rheumatologists, should confirm the diagnostic impression suggested by the history and physical examination. Electrodiagnostic testing has two components, nerve conduction and electromyography (EMG). Nerve conduction studies of the sensory and motor peripheral nerves can determine the site of a peripheral nerve lesion. Electrodiagnostic testing could determine if the weakness is due to a muscle disease (myopathic) or peripheral nerve disease or injury (neuropathic).
5. **Your patient might have a peripheral nerve lesion.**

Your patient has had a dropped foot, such as after a hip replacement, and you are wondering if this is a peripheral nerve lesion. Again, electrodiagnostic testing would be helpful. For example, is the foot drop due to a sciatic nerve lesion or a peroneal nerve injury? Is the hand numbness due to a lesion in the cervical roots, brachial plexus, at the elbow, or carpal tunnel syndrome?

6. **Your patient might require rehabilitative care after orthopedic surgery.**

Your patient is in hospital due to a recent total knee or total hip replacement or a fracture and you are wondering whether the patient would benefit from an admission to a rehabilitation unit. A physiatrist performing a post-operative consultation could determine if the patient has already returned to a sufficient functional level to return home, or whether further inpatient rehabilitation would be helpful in the face of barriers at home (e.g., stairs), comorbid medical conditions and/or a lack of family support. Admission to a post-operative rehabilitation unit can provide intensive daily physiotherapy and occupational therapy. A home visit by a therapist to assess the home situation may also be useful.

7. **Your patient requires care for a spinal cord disease or injury.**

Your patient has had a spinal cord transverse myelitis (e.g., due to SLE or Sjögren’s syndrome [SjS]). Patients with spinal cord diseases or injuries require ongoing care for prevention and treatment of many potential complications including respiratory insufficiency, pressure sores, spasticity, neurogenic bowel and bladder issues, nutrition, spinal deformity, sexual issues, and may require mobility devices such as a wheelchair.

8. **Your patient might need orthotics.**

Your patient has sore or deformed feet and you are wondering about foot orthotics, or your patient has primary medial joint knee osteoarthritis (OA) and you are wondering about a brace. Orthotic devices (which can be purchased over-the-counter or custom-made at greater cost) include braces, splints, corsets, collars, and shoe modifications. A properly prescribed orthosis can improve function and decrease pain by altering biomechanics. Orthoses can decrease forces passing through the entire or part of a weight-bearing joint (such as using a knee brace to off-load the medial compartment of a patient with OA of the medial compartment, or a corset to help mobilize a patient with a spine compression fracture), stabilize subluxating joints (such as an unstable knee due to ligament injury), improve motion patterns (such as reducing the energy requirement for ambulation), and maximize functional position (such as using a static splint to put a weak wrist in the best functional position to use the hand, or by using a dynamic wrist splint to replace finger extension in a rheumatoid arthritis (RA) patient with extensor tendon rupture).

9. **Your patient has had repeated falls.**

Falls in patients with chronic diseases can result in significant morbidity and mortality; they are common, expensive, and preventable. A physiatrist can assess and treat the cause of the falls, which is usually multifactorial. Risks for falls include drugs (e.g., psychotropic agents and diuretics), comorbid conditions such as musculoskeletal, neurological, and cardiopulmonary diseases, and issues of vision, hearing, balance, incontinence, arrhythmia, and orthostatic hypotension. To reduce fall risk, mobility assistive devices could be provided. A home visit by a therapist could be arranged to assess for modification/adaptation of the home to reduce environmental hazards and to install home safety devices.

10. **Your patient has heart or lung disease.**

Your patient has had a myocardial infarction (e.g., due to premature atherosclerosis and lupus) or has a pulmonary issue (e.g., pulmonary fibrosis due to rheumatoid arthritis) and you are wondering whether the patient would benefit from a cardiac or pulmonary rehabilitation program. These programs can be supervised by a physiatrist or cardiologist/respirologist and typically involves exercise training, education and medications with the goal of improving cardiac and respiratory function and quality of life.

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