

Joint and Soft Tissue Problems Develop Over A Period of Time

Tanaka P*

Department of Medicine and Health Sciences, Universiti Sultan Zainal Abidin, Malaysia

Abstract

To completely quantify exposure to a risk factor, the following dimensions are necessary: magnitude of exposure, the duration and the repetitiveness. However, a major drawback of many studies related to physical exposures to risk factors, was that this was not self-reported and focused on one of the three dimensions identified above.

Keywords: Pain status; Campaigns; Equipment; Heterogeneity; Lessons; Interventions

Introduction

While some self-reported exposures are reproducible and may be self-reporting of physical exposure could easily be biased by the subject pain status. Furthermore, common beliefs in different occupational groups about the occupational hazards experienced by their group could also influence self-reports of exposure. Other studies had shown the benefits of protection devices, e.g. kneepads, for providing an effective barrier against lacerations and penetration of the knee during kneeling, as well as for improving comfort by reducing contact stresses, and thereby decreasing risk of compression injuries of the joints, such as bursitis [2]. However, it was not clear whether the devices provided protection against all types of disorders, or against only a subset, those with similar aetiology. These observations suggest that there are gaps in our knowledge about the relationship between symptoms and loading of the body due to hazard exposures. Furthermore, there were doubts about the effectiveness of human factors and organisational interventions, such as guidance, regulations and safety campaigns for encouraging compliance of employers and workers to the safety measures [3]. The results from studies of exercise and keep fit regimes were quite contradictory with some supporting the practices and calling for coping programmes for those with injury, and others arguing against. There are therefore gaps in our knowledge of the benefits of guidance and coping programmes for those with injury, and the suitability of protection equipment strategies for preventing limb needs further investigation [4]. Various outcomes were defined for investigation ranging from specific medical diagnoses such as plantar fasciitis, bursitis, meniscal lesions and venous diseases, to spurious measures such as fatigue, symptoms, pain and complaints. In the majority of the studies ascertainment of pain, symptoms and fatigue was mainly obtained through self-reporting, including the use of the Nordic Questionnaire. The few studies that involved clinical examination or medical diagnosis and investigated relationships between the medical conditions and symptoms, generally reported poor correlations. These suggest that gaps remain in our knowledge of the underlying causes of pain and may also explain why identified

consequences were rarely discussed in relation to specific conditions [5]. The observations further suggest that there are gaps in our knowledge of the relationships between pain in the different regions of the body and between different types of disorders. Knowledge of this kind may be able to inform the design of interventions. The identification of key risk factors and the associated shortfalls may also help to prevent self-reported and focused on one of the three dimensions identified above. The prevention need to be based on key risk factors within the context of the specific occupational setting. Despite the heterogeneity of the methodologies and the associated shortfalls, a number of the risk factors identified repeatedly emerged as significantly associated with pain and in some of the studies, also indicated dose-response relationship [6]. This was particularly true for physical and personal factors, many of which have been directly implicated in the aetiology of MSDs. The physical and personal factors that showed the strongest evidence of causality or association were squatting, climbing stairs or ladders, heavy lifting, standing, slips and trips hazard, gender, age, obesity and personal lifestyle. Those for which there was plausible but less clear evidence included jump from height, driving and sitting. Psychosocial factors often did not show direct causality, but they do contribute to determine the social dynamics of work groups [7]. Additionally, they are increasingly considered to act as modifiers of pain associated with injury rather than initiators of injury and therefore these aspects cannot be ignored. Prevention in the workplace therefore requires the creative use of control strategies to balance the physical and psychosocial demands with the characteristics of the individual. Various interventions have been proposed for controlling the risks and preventing MSDs in the workplace. Those that have been shown to be useful include implementing protective equipment, changing work surfaces, redesign and modification of work methods, training and retraining, and participatory programmes. Indeed, work redesign and modification along human factors principles proved most effective for encouraging behaviour change, rehabilitation and return to work of injured workers, benefits in terms of changes in sickness absence and increase productivity rate were also identified. Implementation of

*Corresponding author: Tanaka P, Department of Medicine and Health Sciences, Universiti Sultan Zainal Abidin, Malaysia, Tel: 096658237, E-mail: tanakap@gmail.com

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