Biopsychosocial

see Biopsychosocial model.

Biopsychosocial variables

Physical function, sleep disturbance, fatigue, pain interference, depression, and anxiety,

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Chronic pain, particularly chronic low back pain, is a common disabling condition with high costs and burdens to society. The biopsychosocial model may provide a framework in which chronic low back pain may be viewed to guide new and emerging clinical care models to achieve the Triple Aim in this field of care [1].

Goudman et al., proposed a shift in educational intervention from a biomedical towards a biopsychosocial approach for people scheduled for lumbar surgery. Pain neuroscience education (PNE) is such a biopsychosocial approach that aims at decreasing the threat value of pain by reconceptualizing pain and increasing the patient's knowledge about pain.

In a paper, they provide a clinical perspective for the provision of perioperative PNE, specifically developed for patients undergoing surgery for lumbar radiculopathy. Besides the general goals of PNE, perioperative PNE aims to prepare the patient for post-surgical pain and how to cope with it [2].

Only 8 studies have investigated the Aneurysmal subarachnoid hemorrhage epidemiology in the United States. In the first investigation in Indiana, which has some of the highest rates of tobacco smoking and obesity in the nation. Ziemba-Davis et al. prospectively identified 441 consecutive patients with aSAH from 2005 to 2010 at 2 hospitals where the majority of cases are treated. Incidence calculations were based on US Census populations. Epidemiologic variables included demography; risk factors; Hunt and Hess scale; Fisher grade; number, location, and size of aneurysms; treatment type; and complications. The overall incidence was 21.8 per 100,000 population. Incidence was higher in women, increased with age, and did not vary by race. One third to half of the patients were hypertensive and/or smoked cigarettes at the time of ictus. Variations by count were partially explained by Health Factor and Morbidity Rankings. Complications varied by treatment. These findings deviate from estimates that 6-16 per 100,000 people in the United States will develop aSAH and are double the incidence in a Minnesota population between 1945 and 1974. The results also deviate from the worldwide estimate of 9.0 aSAHs per 100,000 person-years. The predictive value of variations in Health Factor and Morbidity Rankings implicates the importance of future research on multivariate biopsychosocial causation of aSAH [3].

1)
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2)
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3)
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