Abstracts of Scientific Papers and Posters Presented at Physiatry '26

February 16–21, 2026

SCIENTIFIC ORAL PRESENTATIONS

Academic Physiatry: Has Physiatric Presence Changed Across US Academic Institutions?

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OBJECTIVES: As evidenced by the World Health Organization's Rehabilitation 2030 initiative, medicine's focus is shifting from extending life expectancy to optimizing quality of life and function. Physical Medicine and Rehabilitation (PM&R) is well suited to lead this culture shift; however, PM&R's reach is seemingly limited, with significant disparities in physiatric care and academic presence within the United States (US), particularly in the South, as noted by Perret et al. in 2018. This discussion aims to provide an update regarding PM&R presence in academic medicine.
DESIGN: US medical schools were obtained using the Association of American Medical Colleges and American Osteopathic Association medical school databases, and website searches were conducted to identify PM&R academic entities. Each school was **Design**ated as having either independent departments, shared departments, divisions, or no academic entities. This data was subsequently analyzed by state and region, and the findings were compared to the 2018 data.
RESULTS: The Northeast possessed the most PM&R academic entities with 37.0%, followed by the South with 25.0%, Central with 24.1%, and West with 13.9%. Similarly, the Northeast had the largest relative PM&R presence at 74.1% of schools, followed by Central at 54.2%, West at 38.5%, and South at 32.1%. Compared to 2018, the number of PM&R academic entities grew in the Northeast, South, and West. However, with respect to overall medical school growth, only the Northeast demonstrated growth at 3.9%, while the others demonstrated regression, ranging from −2.6% to −3.5%.
CONCLUSION: While PM&R academic entities have increased since 2018, PM&R's growth is not matching overall medical school growth in the US, especially in the South, which continues to have the largest PM&R deficit. This pace of growth will likely propagate workforce disparities, reduce patient access to appropriate healthcare, decrease UME exposure to PM&R, and minimize PM&R's GME footprint compared to other specialties.

Awareness About Low Back Pain Among Adults in Jordan: A Cross-Sectional Survey

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OBJECTIVES: To assess awareness of LBP among Jordanian adults and identify predictors of higher awareness.
DESIGN: We conducted a cross-sectional survey of adults aged 18–65 years in Jordan (n = 1,951), recruited via social media platforms. The survey collected sociodemographic and lifestyle information and included seven items addressing LBP risk factors and preventive measures (e.g., posture, lifting technique, stress, lumbar support). An awareness index (0–7) was created by summing endorsed items; internal consistency was modest (Cronbach's $\alpha = 0.60$). Logistic and multinomial regression models estimated associations of gender, healthcare worker status, residence, and education with awareness items and index scores.
RESULTS: Mean age was 30.9 (SD 10.7) years; 52.5% were female, 29.5% healthcare workers, and 79.1% urban residents. The mean awareness index score was 5.85 (SD 1.32; median 6, IQR 5–7; range 0–7). Using a median split, 72.1% were categorized as high awareness (≥ 6). Awareness was high for posture (94%), preventive actions (92%), lifting technique (92%), and ergonomic bedding (88%). Only 53% endorsed stress as a contributor to LBP, and 77% endorsed lumbar support. In adjusted analyses, males were less likely to endorse the stress–LBP link (aOR 0.62, 95% CI 0.50–0.77), while healthcare workers were more likely to endorse both stress–LBP (aOR 1.69, 95% CI 1.35–2.12) and lumbar support (aOR 1.69, 95% CI 1.12–2.55). Healthcare workers also had higher awareness scores ($\beta = 0.28$, $P = 0.003$; aOR 1.35, 95% CI 1.11–1.65). Age, residence, and education showed no consistent associations.
CONCLUSIONS: Among Jordanian adults, overall awareness of biomechanical risk factors for LBP was high, with nearly three-quarters categorized as high awareness. Recognition of psychosocial influences such as stress was limited. Healthcare workers demonstrated significantly greater awareness. These findings highlight the need for public education initiatives that emphasize psychosocial dimensions of LBP.

Bridging Oncology and Rehabilitation: A High School Curriculum Model for Early Exposure to Interdisciplinary Cancer Care

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CASE DIAGNOSIS: Progressive Multifocal Leukoencephalopathy (PML) / HIV Encephalitis
CASE DESCRIPTION: PML, a demyelinating disease caused by JC virus reactivation, and HIV encephalopathy are both AIDS-defining conditions that may present with cognitive and motor dysfunction in immunocompromised patients. This is a case of a 47 year old African American female with medical history significant for congenital hip dysplasia who presents to the acute rehabilitation unit with tardive dyskinesia-like symptoms including involuntary facial movements, dyskinesia of the extremities.
DISCUSSIONS: Patient was discharged from acute hospital where she presented with encephalopathy and fever to 103.2°F, prompting workup for autoimmune encephalitis. Empiric acyclovir, ceftriaxone, and vancomycin for possible meningitis/encephalitis were started but discontinued shortly after negative studies. Initial workup, including EEG with generalized slowing, CSF, and spine MRI was unrevealing. MRI brain was limited due to motion artifact. During acute rehab she developed worsening encephalopathy, confusion, and dyskinesia requiring transfer. Further testing revealed HIV with viral load 139,000 and CD4 of 6. MRI was concerning for PML versus chronic HIV encephalopathy. Repeat CSF showed HIV VL 77,900. She was CMV IgG positive with low-level viremia but no retinitis, and JCV antibody positive, indicating prior exposure. She was started on HAART and PJP prophylaxis with significant improvement, able to engage in therapies during acute rehab, and ultimately discharged home with HIV clinic follow-up.
CONCLUSIONS: This case highlights the importance of considering HIV/AIDS in the differential of encephalopathy and movement disorders, especially in patients without prior medical history suggestive of CNS opportunistic infection.

Proximal Leg Weakness Following Varicella-Zoster Virus Infection: A Case Report of Segmental Zoster Paresis

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CASE DIAGNOSIS: A 71-year-old man presented with acute right-sided proximal leg weakness and dysesthesias following a herpes zoster rash in the L3–L4 dermatome. He was diagnosed with segmental zoster paresis (SZP), a rare motor complication of varicella-zoster virus (VZV) reactivation.
CASE DESCRIPTION: The patient developed a dermatomal vesicular rash, followed by sensory symptoms and progressive leg weakness during the rash outbreak. He received oral antiviral therapy without clinical improvement in two months. Electrodiagnostic studies showed acute denervation in L3–L4-innervated muscles, most consistent with radiculopathy. MRI of the lumbar spine and lumbosacral plexus excluded concurrent compressive or infiltrative causes. He began intensive outpatient rehabilitation. Fluoroscopically guided transforaminal epidural steroid injections were trialed without significant relief of dysesthesia or motor deficit. At seven months, he has demonstrated gradual motor recovery.
DISCUSSIONS: SZP is an underrecognized complication of VZV reactivation, occurring in approximately 0.5–5% of cases, with higher prevalence in older adults and immunosuppressed individuals. Weakness typically arises within days to weeks of rash onset and **Results** from viral spread from the dorsal root ganglion to motor neurons. Prompt diagnosis facilitates timely antiviral therapy, which may reduce the risk, severity, and duration of paresis. It also prevents misdiagnosis as structural radiculopathy and enables appropriate rehabilitation planning. Diagnosis is clinical, supported by electrodiagnostic findings and variable MRI changes. NAAT or CSF PCR may assist in atypical cases.
CONCLUSIONS: SZP is an uncommon but clinically significant cause of acute limb weakness, particularly in older adults. Early recognition—via EMG, imaging, and viral testing—not only guides management but also helps avoid unnecessary interventions. Antiviral therapy may lessen symptom burden and promote recovery. Although two-thirds of patients recover fully or nearly so, persistent deficits may occur, especially with severe initial weakness or advanced age. Physiatrists play a critical role in timely diagnosis, interdisciplinary care, and rehabilitation.

Pusher Syndrome Following Stroke: Rehabilitation Challenges and Strategies

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CASE DIAGNOSIS: Pusher Syndrome
CASE DESCRIPTION: A 68-year-old woman developed left hemiparesis with mild weakness after a right thalamic infarct. During rehabilitation, she persistently tilted her trunk toward the paretic side and resisted correction to midline, using her stronger arm to push away from the intact side. Despite preserved vision and no major sensory loss, her postural control was severely impaired. Her Scale for Contraversive Pushing (SCP) score was 6 out of 6, consistent with severe Pusher Syndrome. These behaviors caused repeated imbalance and required maximal assistance for sitting and transfers, delaying gait training. Rehabilitation included mirror visual feedback with a vertical reference line, environmental alignment during postural tasks, task-specific training such as upright sitting and sit-to-stand with emphasis on even weight distribution, and consistent verbal cueing. Caregiver education reinforced safe mobility strategies. Over eight weeks, she improved from severe to minimal pADL dependency, with SCP score reduced to 0, restored balance, and supervised walking.
DISCUSSIONS: Pusher Syndrome occurs in approximately 5 to 10 percent of stroke survivors, most often with posterolateral thalamic lesions. It is characterized by an altered perception of vertical orientation, rather than primary motor or sensory deficits, leading patients to actively resist correction and push toward the paretic side.