

reactivate

PUTTING **ACTIVITY** BACK INTO YOUR LIFE

Quarterly **PHYSIOSOUTH** Newsletter

Winter 2007

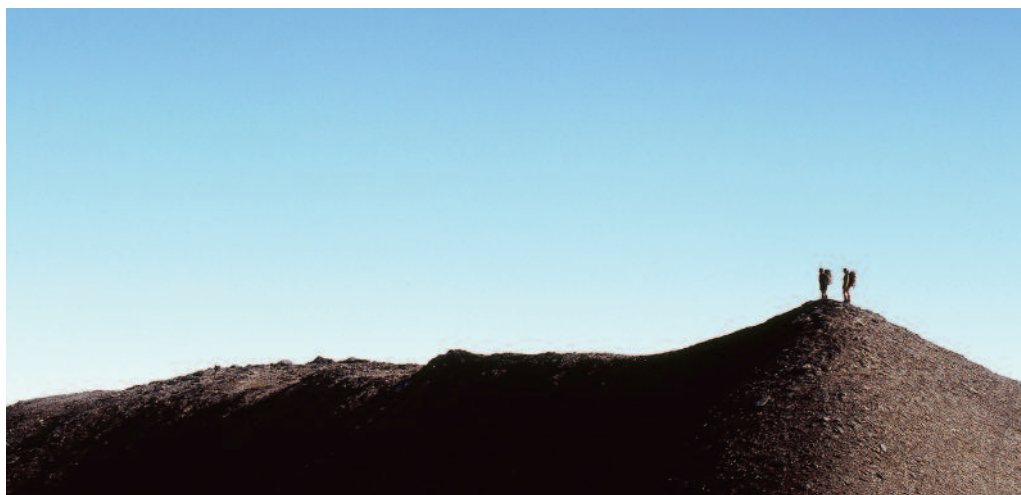


PHOTO: MARK WATSON/FUNKENCLIMB.CO.NZ

Contact

FREEPHONE
0508 4 PHYSIO
0508 4 7 4 9 7 4

PH 332 6487
FAX 337 2052
A/H 0274 331 965

Clinic Locations

PHYSIOSOUTH
167 Colombo Street

PHYSIOSOUTH@PROFITNESS
Moorhouse Avenue
Harvey Norman Building

PHYSIOSOUTH@PROFITNESS
Northwood
Belfast Supa Centa

PHYSIOSOUTH@PIONEER
Pioneer Leisure Centre

PHYSIOSOUTH@MOORHOUSE MEDICAL
3 Pilgrim Place

PHYSIOSOUTH@KAIAPOI
Unit 6 /77 Hilton Street

PHYSIOSOUTH@CRICHTON COBBERS
177 Chester Street East

MODIFYING YOUR ATTITUDE

John – a weight-loss case study

'I used to come to the gym because I had to—to get paid by ACC. Now it is not a hassle to come to the gym because I am motivated. I am only 24 years old and don't want to waste my life sitting at home eating junk food on the couch.'

John's shoulder injury limited the work he was able to do as an engineer or be involved in sport. As he became less active he became depressed and other negative issues started to creep into his life. The result of this was that his body weight increased 17kg from around 95kg to 112kg in just 11 months.

John would sleep in, get up late, and watch TV. The only exercise he was doing was to go to the dairy to get his daily ration of Coke, V, chocolate milk or cakes. He regularly consumed McDonalds, fish and chips, and crisps.

Ironically John's injury became the turning point for his reactivation. By attending **PHYSIOSOUTH'S** Kaiapoi clinic he was under the expert guidance of Brendon Meffan to fully recover from his shoulder surgery. While on a gym-focused Activity Based Programme **PHYSIOSOUTH** also provided John with expert nutrition and weight loss guidance from Dane Fuller of www.eatfit.co.nz – personal nutrition and exercise consultants.

John discovered his internal motivation. He realised that he has so much to live for and that exercise and nutrition are the path to a new life. He is getting up every morning to start his day off at the gym with three weights and two cardio sessions. For fitness he also volunteers to get up early and help his cousin on a recycling run.

John now has regular employment. His family ask him why he eats less at dinner. His friends ask why he doesn't have McDonalds with them and waits to make a sandwich when he gets home! He is encouraging his step dad and mum to join him in eating healthier. He has joined the local rugby league club and with his shoulder fully recovered and his weight closer to 100kg he is now looking forward with optimism to the season ahead.

EAT YOURSELF FITTER

Dane Fuller was recently contracted as the **PHYSIOSOUTH** Nutritionist and Exercise Consultant. Dane offers a service specialised in achieving a healthy weight.

He has qualifications in Nutrition and Exercise and experience as a New Zealand University lightweight rower.

Eatfit – Personal Nutrition Training is a nutrition and weight loss service. Nutrition made simple. No diets. No calorie counting. Routines, habits, and lifestyle change. **Eatfit** recognises that emotion and support are crucial to achieve a long term healthy weight along with education.

Eatfit guarantees to make a difference in your life or your money back – no questions asked. This is a committed healthy weight service with professional support.



The Functional Goal

A simple but extremely powerful tool physiotherapy uses almost universally (but with many degrees of emphasis) is the Functional Goal. This simple agreement between treatment provider and patient provides a series of extremely positive benefits. Some of these are:

- A realistic and timed return to a defined level of function.
- Patient has expectations.
- Patient has a belief that it will happen, and when.
- It is function focused and not pain focused.
- As it is patient centred, it creates a desire.
- Once both parties agree what the goal is it is not too hard to sort out the path needed to achieve it.

The Goal

The healthy brain is to some degree goal focused (*D Amen, from 'Making a Good Brain Great'*). Achievement with a physiotherapy 'functional goal' is often the first written goal some achieve, or it can awaken the process which was once active. Setting a goal is similar to a setting thermostat (*S Segerstrom 'Breaking Murphy's Law'*). If the temperature needs to change, action is required. We generally know what temperature we want and which direction we should go to achieve it. We monitor the process. When we are uncomfortable with our current situation we set a goal, we aim for a change. We ideally monitor the change and set about the actions required. Learned Helplessness is the state of 'Nothing I do matters' (*M Seligman 'Authentic Happiness'*) therefore there is no belief of change and no action taken, no goal set. Change does not happen.

Exercise and the Goal

When the goal is achieved, combined with exercise, other benefits flow (*D Amen, from 'Making a Good Brain Great'*). Evidence exists for the following:

- Protecting brain cells against toxins, including radicals.
- Repairing cellular DNA to help protect against cell death.
- Reducing the risk of cognitive impairment and dementia due to Alzheimer's Disease by about 50% in people over 65 years old.
- Preserving mental abilities after age 70.
- Reducing the risk of heart disease and stroke.
- Reducing the risk of diabetes
- Reducing the risk of osteoporosis
- Reducing the risk of depression
- Reducing the risk of colon and breast cancer.
- Reducing the risk of falling
- Improved function and reduced knee pain with strength training in people over 70.

Exercise and goals achieved by exercise demonstrate that 'what you do does matter', it often leads to goal setting and achievement in other areas of life.

My point is simply that the supervised physiotherapy goal can be one of the first goals achieved (if not forever, for a while), it is a positive step forward and results in well celebrated and defined outcomes of something meaningful to the patient.

At **PHYSIOSOUTH**, we understand this power and try at every opportunity to 'put activity into the lives of our clients', the rest can and often does follow.

Eat fat or eat fit?



Learn to make the healthy choice with your personal exercise and nutrition consultant.

You are not alone. We are always there for you. Weekly nutritionist and exercise consultations, kitchen makeover, phone calls and text messages.

Christchurch's only professional healthy weight nutrition and exercise programme.

www.eatfit.co.nz

ph PHYSIOSOUTH for appointments: 332 6487

ph after hours 021 117 67 17



Recent publications of interest

Diagnosis and Treatment of Sacroiliac Joint Pain (*Robinson et al. 72-79*)

There is now another paper published confirming that pain provocation SIJ tests are reliable individually, and in clusters. The six tests these authors evaluated include three previously identified as reliable and valid in relation to the reference standard of fluoroscopically guided intra-articular diagnostic blocks.

Mechanical sacroiliac joint pain (*Horton and Franz*)

A case study of a patient that satisfied the clinical criteria for SIJ pain is presented in another paper. This patient was fully examined using a McKenzie (MDT) method of evaluation and no centralisation or directional preference was identified. The lack of directional preference and centralisation significantly reduces the probability of a discogenic source of pain (the most common), and increases the diagnostic accuracy of the SIJ provocation tests (Laslett et al. 89-97). This patient was further evaluated with repeated SIJ rotation tests and found to have a directional preference to one direction i.e. anterior rotation progressively decreased the pain and posterior rotation progressively improved it. The patient was successfully treated with self mobilisation to anterior rotation in a matter of days even though the symptoms had been present consistently for two and a half years. The patient was seen seven times over a four week period. This case study illustrates that the McKenzie MDT system of examination and management may be extended to include non-spinal pathologies successfully, and that self mobilisation of the SIJ may be effective in selected cases.

Centralisation and directional preference is a common finding in spinal pain cases (*Hefford*)

Centralisation and directional preference are phenomena that are identified during a specific type of clinical assessment—the McKenzie MDT (Mechanical Diagnosis and Therapy) method. Centralisation is the progressive reduction of referred pain and movement of pain towards the spinal midline during the MDT assessment of repeated movements and sustained positions. Directional preference is the phenomenon observed where one direction of mechanical loading causes progressive centralisation and/or reduction of pain, and, another (usually opposite) direction, causes pain to progressively worsen or spread further from the spinal midline (peripheralisation). The MDT assessment uses simple highly standardised movements and postures which are mostly done by the patient. The testing procedure is reliable when carried out by appropriately trained clinicians (Kilpikoski et al. E207-E214). A recent study done here in New Zealand has documented the prevalence of centralisation and directional preference among spinal pain patients. 34 experienced physiotherapists trained in the MDT methods examined 321 consecutive spinal pain patients seen mostly in private clinic environments. 75, 81 and 87% of low back,

neck and thoracic spine pain patients reported centralisation or directional preference. Given that centralisation/directional preference is a good predictor of a rapid recovery when the direction of preference guides exercise and mobilisation treatment (Long 2513-21; Long, Donelson, and Fung 2593-602), it is apparent that movement specific treatment is likely to be successful for the great majority of these patients.

Rapidly Reversible Low Back Pain by Dr Ronald Donelson (*Donelson*) is a new book on diagnosis, classification and management of back pain. The first several chapters are especially important reading for all parties involved in the management of spinal pain patients. The book is

extremely easy to read yet tackles the problem of inappropriate and misinterpreted past research that continues to confound the problem of best practice. National guidelines on best evidence practice for acute and chronic back pain are extremely consistent internationally and as Dr Donelson points out, are based on randomised controlled trials accepting the precondition that back pain is a homogeneous condition (i.e. all back pain has a single source or cause). The fact that it has been known for many years that back pain populations are very heteroge-

neous, has not deterred guideline developers, and is a persistent source of misdirection of research efforts, compensation of patients and funding of treatment methods. He lucidly and comprehensively reviews the literature in easy language and illuminates the lack of attention to the growing and reasonably voluminous literature supporting the McKenzie MDT methods of assessment and management. This book is focused primarily on the majority of cases that report centralisation and directional preference—the rapid responders to simple methods such as posture correction, simple exercises and simple manual therapy methods of the MDT system. All physiotherapists, doctors, chiropractors, osteopaths, back pain researchers, ACC case managers, ACC and government guideline developers and research funding agencies should read this book, and soon!

Donelson, R. *Rapidly Reversible Low Back Pain: an Evidence-Based Pathway to Widespread Recoveries and Savings*. Hanover, New Hampshire: Selfcare First, LLC, 2007.

Hefford, C. *McKenzie classification of mechanical spinal pain: Profile of syndromes and directions of preference*. Manual Therapy [In press], 2007.

Horton, S. J. and Franz, A. *Mechanical diagnosis and therapy approach to assessment and treatment of the sacro-iliac joint*. Manual Therapy [Epub ahead of print August 4], 2006.

Kilpikoski, S., Airaksinen, O., Kankaanpaa, M., Leminen, P., Videman, T., and Alen, M. *Interexaminer reliability of low back pain assessment using the McKenzie method*. Spine 27 [8], E207-E214. 2002.

Laslett, M., Young, S. B., April, C. N., and McDonald, B. *Diagnosing painful sacroiliac joints: a validity study of a McKenzie evaluation and sacroiliac joint provocation tests*. Aust J Physiother 49, 89-97. 2003.

Long, A. *The centralization phenomenon: Its usefulness as a predictor of outcome in conservative treatment of low back pain: A pilot study*. Spine 20, 2513-21. 1995.

Long, A., Donelson, R., and Fung, T. *Does it matter which exercise? A randomized control trial of exercise for low back pain*. Spine 29[3], 2593-602. 2004.

Robinson, H. S., et al. *The reliability of selected motion- and pain provocation tests for the sacroiliac joint*. Man. Ther. 12.1 (2007): 72-79.

