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Crisis of princely proportion

As a teenager in the ’80s, making a mix tape from cassettes was a huge thing. It was our version of today’s iTunes music library except, we actually had a physical library of cassette tapes.

The shocking news of Prince’s death last April took me back to those collection of mix tapes, where many of his all-time-favourite hits reside – another legendary music icon of my childhood gone from this world.

The Midwest Medical Examiner’s Office in Ramsey, Minn., released its findings of cause of death as accidental overdose of the opioid analgesic fentanyl. Other than this official press release, there aren’t very many details being disclosed surrounding the death of the “Purple Rain” maker.

Media reports have cited sources close to the 57-year-old superstar, saying Prince had been suffering for years from hip and knee pain, and events leading up to his death rose speculations of prescription painkiller dependence.

We might never know the real story here, but Prince’s tragic ending brings to light an important issue that observers are calling a public health crisis: the unprecedented increase in painkiller prescriptions, use and abuse. Prince joins a growing list of famous talents taken from this world by similar means. But the number of celebrities killed by opioid overdose in North America is only a small fraction of the tens of thousands of regular folks who have died – and continue to die – from prescription painkiller overdose.

Abuse of prescription painkillers is a growing epidemic that needs serious attention, not only when huge celebrities are involved.

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Abuse of prescription painkillers is a growing epidemic that needs serious attention, not only when huge celebrities are involved. With the increasing prevalence of chronic pain among adults and the continued indiscriminate prescribing of high-dose pain medications by physicians, we can only expect the opioid crisis to persist.

There has to be a better alternative than handing patients prescription slips to ease their pain. There is an abundance of good evidence out there pointing to non-opioid alternatives to pain management.

Massage therapy and other complementary and alternative medicine providers have a huge role to play in addressing this opioid crisis. I hope they are given the opportunity to make a difference in people’s lives.

“Abuse of prescription painkillers is a growing epidemic that needs serious attention, not only when huge celebrities are involved.”
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PAIN MANAGEMENT

Self-care yields better chronic pain outcomes

The National Pain Strategy, released this year by the U.S. Department of Health and Human Services, places strong emphasis on self-management and patient education as critical pathways for improving treatment of chronic pain, especially back pain.

At the recent American Pain Society’s (APS) Annual Scientific Meeting, researchers representing the U.S. Veterans Affairs (VA) and North American Spine Foundation discussed implications of the National Pain Strategy for improving pain management and reducing disability.

Some 100 million Americans have chronic or persistent pain, according to the Institute of Medicine, and back pain is the leading cause of disability for people under 45 years of age. The VA estimated in one study that 44 per cent of soldiers in an Army infantry brigade reported chronic pain three months after returning from tours of duty in Afghanistan and Iraq – double the rate among civilians. The North American Spine Foundation says spinal disorders have increased by 300 per cent in the last 50 years and now rank as the number-one cause of disability in the United States and in the military.

Robert Kerns, Ph.D., professor of psychiatry, neurology and psychology at Yale University, spent 38 years practicing in VA health care, most recently the VA Connecticut Healthcare System. He reported in a panel presentation at the APS meeting that the VA’s stepped-care model to help veterans better manage their pain through standardized pain assessments, alternative therapies, patient education and self-care is succeeding in reducing opioids use.

“The proportion of VA patients receiving high doses of opioids has decreased significantly in the last four years concurrent with greater use of non-drug alternative pain therapies,” said Kerns.

Kern cited better self-management and patient education as examples of new ways the VA is working to improve pain care for veterans, and believes the National Pain Strategy’s strong advocacy of self-care will provide more educational resources and greater incentives to help physicians empower their patients to become more proficient at managing and coping with their pain.

In his panel presentation, Michael Reed, executive director, North American Spine Foundation, addressed the importance of emphasizing function to prevent or minimize disability in people with spinal disorders. “The current treatment paradigm addresses pain first and function second, but it should be reversed,” said Reed. “The pendulum may have swung too far forward in addressing pain and not function, so we need to emphasize both in balance.”

The North American Spine Foundation has established National Spine 10x25 Initiative, a public and professional awareness campaign designed to reduce U.S. spine-related disability by 10 per cent by 2025.

WHAT’S ONLINE

Useful web videos to watch on MassageTherapyCanada.com

A web series hosted by veteran RMT Don Dillon, featuring commentaries on developments affecting the massage therapy profession

A new video series offering RMT practitioners insights on the latest techniques and technologies related to practice
Massage therapy effective pain management option: study

Massage therapy can provide significant improvement for pain, anxiety and health-related quality of life for those looking to manage their pain, according to a collaborative meta-analysis of research on massage therapy for pain conducted by Samueli Institute and commissioned by the Massage Therapy Foundation.

The first part of the three-part review and analysis was published online by the journal Pain Medicine.

Pain is a major public health concern, affecting approximately 100 million Americans. It is currently recognized as the most compelling reason for an individual to seek medical attention, and accounts for approximately 80 per cent of physician visits. It is estimated that chronic pain accounts for approximately $600 billion in annual health-care expenditures and lost productivity.

Based on the evidence, massage therapy – compared to no treatment – should be strongly recommended as a pain management option. Massage therapy is conditionally recommended for reducing pain, when compared to sham or other active comparators, and improving mood and health-related quality of life, compared to other active comparators.

Pain is multi-dimensional and may be better addressed through an integrative approach. Massage therapy is commonly used among people seeking pain management and research has generally supported its use. But, until now there has been no published, rigorous review of the available research and evidence for its efficacy for pain populations.

Continuing Education

Burlington hosts Ontario sport RMT forum

The Canadian Sport Massage Therapists Association (CSMTA) Ontario Chapter 2016 annual general meeting (AGM) and conference took place at the Burlington Waterfront Hotel on May 1st.

A fantastic agenda was put together by the AGM Organizing Committee, which started with Remo Bucci telling attendees everything they needed to know about being a sport massage therapist. He discussed in detail what it’s like to travel to major games. The highlight of his presentation was his talk about the effects of this travel on one’s personal life – a very truthful, enlightening and thought-provoking account of his experiences.

Next on the agenda were two of Canada’s track athletes that participated in the 1992 Barcelona Olympics – Freddie Williams and Mark McCoy. Williams is a five-time Canadian 800m champion, held the Canadian 800m record at 1:45:13 for 10 years and was the captain of the Canadian Track & Field Team for the 1992 Barcelona Olympics. McCoy has won several gold medals in hurdles and 4x100 relays, but most notably, he won gold in the 110m hurdles at the 1992 Barcelona Olympics.

The two athletes spoke of their life experiences, their paths to the Olympics and the importance that massage therapy played in their roles as elite athletes. While they contrasted in their views of competition, both were very entertaining, inspiring and an excellent combination to have as speakers. Their thoughts and reflections made an indelible impression on all attendees. Many thanks to Ottawa CSMTA member, Paula Burchat, for her outstanding and insightful moderation of this segment.

The afternoon brought an informative, well-executed and interactive presentation by Jonathan Maister, with discussions on “The Hip.”

Jonathan touched on the applied anatomy, related this to common injuries to the hip and showed attendees how to address these with hands-on techniques including fascial work, mobilizations and articular pumping.

All techniques were extremely effective and clinic-usable the next day.

Finally, the Ontario Chapter AGM commenced. At the AGM, attendees discussed important issues that are facing sport massage therapists in Ontario. Elections were also held for open positions in the executive committee of the Ontario Chapter.

The newly elected chapter executive committee members include: Maxine Featherstonhaugh, president; Jonathan Maister, vice-president; Gillian Samuel, secretary; Joanne Glassford, treasurer; Karen Hyslop, Ontario Chapter representative; Lindsay Geiger, public relations chair; Jason White, education chair; Amaya Iribarren, events chair; and Kristy Wiltshire, past president.

The CSMTA Ontario Chapter executives commended the AGM Organizing Committee for a great job of putting together an enjoyable and inspirational day. The event was sponsored by Know Your Body Best.

The Ontario Chapter is now busy preparing to host the CSMTA National AGM in October 2016.

- By Maxine Featherstonhaugh and Karen Hyslop
work with a dynamic population of seniors that wish to remain active and also continue in the workforce.

In today’s reality, most seniors still need to work because pensions are not enough and they have to continue earning an income to support their daily lives and those of their family’s. A RMT needs to consider all aspects of the patient’s life, and how they cope with the physical, emotional, mental and social stressors that they face.

The health history is fundamental to the next steps of treatment. It is imperative that we delve deep into the life of the client. Seniors have 60 or more years of history behind them, all of which have affected the growth and development of their bodies and the attitude they choose to move forward with. It is vitally important to find out how those years have impacted their body. This is where we start understanding the fascinating life history of fascia.

As RMTs we understand perfect posture, and we know that a postural assessment is fundamental and should be done – even if only providing relaxation treatment. This is an eye opener and should not be taken lightly. As an assessor, we need to see the history unfolding in front of our eyes. We see structures that have been used more than others and less than some, deviations from the norm, atrophy, hypertrophy, joint mechanics, balance and compensation patterns of frequent activities.

The postural assessment tells a unique story as each individual is very different – like a fingerprint. For example, a frequent golfer may show a rotational pattern in the direction of his swing or a desk worker shows the slumping posture of a forward head, kyphotic spine and protracted scapulae.

A great aspect of working with the elderly is that the patterns are so well pronounced. The biggest difference between a younger model is the condition of the tissues. With the elder postural assessment, you clearly see the deviations from the norm because there has been a greater time lapse for them to show.

Some of the things an elderly patient hears after an assessment are that they have lost height, that there are degenerative discs, fused vertebrae, and arthritis in their bodies. Muscle structures are weak, or other soft tissue structures show fibrosis and scarring, or connective tissue shortening. Also, that the relationship between agonist, antagonist, synergist and stabilizing muscle structures is out of balance causing the firing sequence to be out of whack. This is the aging population.

During intake and assessment, it is important to include the patient. In fact, they should be uncovering the story of their body with you. I have a skeleton in my practice and I use that skeleton to pull the joints into the posture that I see in my patient. I do this in front of my patient so they can see what I see. I explain exactly what is happening to the joints and soft tissue structures, because if I were to give remedial exercise they now understand what it’s supposed to do. I try to relate what I see to what they have told me during the history intake. By simply explaining how painful patterns develop and form through habitual activities, poor ergonomics and joint mechanics, the patient tends to be much more aware of how they use their body.

So let’s say the patient is suffering from headaches. You get the patient to show you on your trigger point charts the type of referral pattern they are experiencing. If there are trigger points in the SCM muscles causing headaches, and they have a head forward posture, that’s an obvious relationship. I take my skeleton, I show the patient where SCM attaches and then I mimic the action of the SCM muscles and pull the head forward and down towards the clavicles. It’s easy for the patient to see what’s happening in their own body and it’s easy for them to understand how they need to stretch the SCM muscles. Your patient feels very educated and really understands what they are experiencing.

Naturally, the body strives to find balance, and the time spent in a certain posture causes the body to adjust to that posture. For the elderly, it’s even more important because they have likely been repeating a certain habit for a number of years. These holding patterns are typical of the nature and behaviour of fascia.

I have found that when involving a patient in their own assessment, they become a more responsible component of their own outcomes. The great reward in treating seniors is that they have an aptitude for learning new things, they love being involved and in control of themselves. As RMTs, we have unique training about the body, so why should we not teach our patients? When we involve them in their

**Business of baby boomers**

A fascial approach to effective treatment of active seniors  **BY DWYNWYN DROPO**

---

DWYNWYN DROPO is a registered massage therapist and owner of RMT-MEDIC, a massage therapy clinic based in St Catharine’s, Ont. Her practice focuses on repetitive stress and strain injuries, poor posture and poor ergonomic/habitual compensation patterns. Over the last 10 years Droppo has worked as an independent contractor for multiple clinics and taught for four years in community and private colleges in Ontario.

Seniors have 60 or more years of history behind them, all of which have affected the growth and development of their bodies.
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Given G. Cortes, RMT, Little Current, ON

This course was exactly what I had been looking for – it was challenging, motivating and interactive. I was able to implement new skills and concepts learned immediately after the first unit and two years later I am still evolving and expanding my treatments combining acupuncture and massage therapy. Best of all, graduates have access to ongoing support and feedback from clinical instructors and staff, which I have found to be priceless.

Tonia Nisbet, RMT, Sarnia, ON

The McMaster Contemporary Medical Acupuncture program provides a modern medical interpretation of an age-old treatment modality, helping to explain some of the mysticism associated with traditional acupuncture. The integration of acupuncture with modern neurophysiological concepts, neuroanatomy, functional assessment and evidence-based protocols provided me with a wealth of practical knowledge that could be immediately integrated into my practice with astonishing results. The clarity, content and presentation of the curriculum, as well as the faculty, are second to none. Classroom lectures, practical workshops with countless supervised needle insertions and invaluable hands-on anatomy lab instruction created a well-rounded educational experience that left me feeling completely confident in my abilities.

I can’t say enough about your program! I will definitely be back for your advanced courses. Ken Ansell, RMT, Regina, SK

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A number of years ago I conducted my practice out of a fitness club. In the busy lobby it was common that, while awaiting my next appointment, an existing patron would approach me.

“Don, my hip is sore and it’s affecting my workout today… can you help?” I would explain I only had five to six minutes before my next appointment, but ask them to come in to the therapy area and I will see what I can do.

In the short time-span available to me, I was confined to focus my assessment and intervention. I only did what was necessary to return the affected joint’s mobility and reduce the pain. The person would often report complete relief from symptoms and return to their workout, despite only a five-minute intervention. I wondered to myself, “Why did I believe I needed at least an hour to be efficacious?”

Have you ever critically examined your delivery of care model? Is it the same one you adopted from your original training? The standard model can be time and labour intensive and subject the practitioner to strain and fatigue – limiting work capacity and, therefore, income capacity. Pricing of the services may not reflect true market value, and the persons who can benefit from these services may be generically marketed to, missing your offer entirely.

What if you were to unpack all the components involved in your delivery of care model, and cross-reference them with the patient/practitioner experience?

Take a piece of blank paper and try this exercise. Along the side column, write the variables in your delivery of care model. These may include attract attention (marketing), intake/case history and assessment, providing your professional opinion, treatment intervention, measure outcomes, prescribe self-care, and follow up.

At the top of the page, list the variables included in the patient (client) or practitioner experience you’d like to scrutinize. Examples include time, technique/tools, technology, tangible outcomes, team and take-home pay.

Cross-reference the delivery of care variables with the patient/practitioner variables. What would happen, for example, if you injected technology into your intake and assessment component? What if you incorporated a hand tool into treatment intervention? Could you, as in the example I narrated above, provide effective relief of symptoms in a shorter time-frame? Could you prescribe self-care via technology (i.e. videos) to educate your patients, or incorporate technology (i.e. social media, website, direct email marketing) to promote your practice?

Can you incorporate practice management software technology into your marketing, intake, invoicing and electronic payment, or to record your treatment notes, measure outcomes across your practice and follow up consistently with your existing patients? Can you increase your take-home pay by reconfiguring something...

Scott Grisewood, RMT, applies surface EMG to a patient to demonstrate changes in muscle recruitment patterns.
in your delivery of care variables? Of course you can.

Scott Grisewood, a RMT from Barrie, Ont., uses shockwave therapy – a modality that uses acoustic sound waves to treat tendonitis and various musculoskeletal injuries. Grisewood works with many high-level athletes and combines this treatment with the use of quantitative measuring devices, such as surface EMG, to demonstrate changes in muscle recruitment patterns, force plates to measure balance and gyrometers to measure range of motion. He describes it as a “data driven” approach to assessment and treatment.

By infusing technology and tools while providing tangible outcomes, Grisewood affects his delivery of care model and earns a six-figure income. Grisewood advocates for RMTs to push themselves to higher levels of recognition and status in delivering rehabilitative services, and he demonstrates this by going outside the conventional delivery of care model most massage therapists adhere to.

RMT Donnie Smith, of Dundas, Ont., was told during his massage therapy training not to expect much in terms of compensation. He was told by his well-meaning instructors that RMTs, if they worked hard, could gross $50,000 to $60,000 a year. Male RMTs typically earn less. Donnie was a competitive mountain bicycle racer, knew his target market, and decided during his training to invest in learning a technique popular with athletes: active release technique, or ART.

Smith incorporated several variables to his practice:
- **Technology** – videotaping athletes running before and after treatment
- **Team** – hiring McMaster medical students to assist him with the active movements required of the patient
- **Technique/tool** – using ART, which is popular with athletes and celebrities
- **Time** – treatments were 15 minutes in length

By thinking differently about his delivery of care model, Smith would gross $150,000 a year, three or four times the average massage therapy income at the time. You can review Donnie’s story in the Autumn 2004 edition of *Massage Therapy Canada* magazine online.

So what patient/practitioner variables can you change to improve your outcomes, your delivery of care and your income? You may experiment with one or two variables at a time, or decide on a massive shift away from convention.

Whatever you do, post your trials and results on the *Massage Therapy Canada* website. We can all learn from your example.

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**Business of Baby Boomers**

Continued from page 8

care they are motivated and understand that their input and actions greatly influence their rehabilitation process. It’s not just our assessment of their condition but the way we involve and educated them on their condition. They become excited and an active participant in their own care.

When it comes to the assessment and treatment aspect, RMTs have to be knowledgeable in so many areas – anatomy, physiology and pathology, joint mechanics, ligaments, tendons, muscles, strong and weak, short and long structures, the list goes on. With the senior population, a RMT’s selection of manual muscle tests, special orthopaedic, and neurological tests needs to be even broader because at times there are limitations in the application of some tests.

Once assessment results are established, the selection of massage therapy techniques needs to be very specific.

My focus for the elderly patient is fascia – the system that is the most adaptational in the body, a system that has a memory for habitual patterns, and responds primarily to repetitive stress and strain. The word tensegrity is the best way to describe the nature and behaviour of fascia.

When your patient understands how fascia conforms, adapts and moulds to habitual patterns, they tend to be more aware of themselves and how they behave in everyday life. With elderly patients their patterns are more obvious, and when you bring it to their attention they see it clearly.

You can go one step further and draw their posture on an anatomical posture chart and explain what your assessment findings revealed. They clearly see their deviations from the norm. It’s great to do this because you can explain exactly where you will be treating and why.

Sometimes, patients don’t like what they hear or see with regards to their assessment. It’s a reality check. RMTs have a responsibility to educate and inform, but it needs to be done in a tactful, kind and sensitive manner. We are all habitual beings and everybody has deviations from the norm. That is why setting realistic goals will motivate the patient and they won’t feel so bad about themselves.

As RMTs we have to ask ourselves: “What are the realistic goals for this client?” Take into consideration the health and the condition of the tissues and what this client can realistically achieve. Is the body capable of standing change at this age, in this condition? Is the tissue able to undergo a transformation or is this a case where the patient needs to seek a referral? The therapist needs to understand levels of tissue hydration, nutrition, neurological innervation, and chemical influence such as hormone levels. Also, consider the patient’s willingness to change.

How the patient responds to your approach of care and treatment planning is an integral part of their outcomes. Let us teach people about their bodies, let us show the beautiful relationship we have with ourselves.
Star struck
Rubbing elbows with celebrities is a typical day in the life of these RMTs
BY STEFAN DUBOWSKI

You may not recognize the names of the massage therapists profiled below, but you might recognize their patients: singers, actors and elite athletes.

These are not your typical clients. So how do RMTs develop unusual practices focused on particular niches? Read on to discover extraordinary paths to success, and perhaps some tips to help you build a name for yourself in the area you want to target.

Therapy in the key of Carole
Carole Wakefield is a RMT in Wainwright, Alta. She has worked for countless pop, rock and country music stars on tour across Canada, including many who perform at Rexall Place in Edmonton, where Wakefield is the resident massage therapist for touring music acts. Managers who work for luminaries such as Britney Spears, Van Morrison, The Eagles and Reba McEntire have all called on Wakefield to provide massage therapy for crews and musicians.

She certainly has worked with many high-profile performers. But many of her patients are also the folks who usually stand behind the stars.

“There are so many different people and jobs to make the tour run,” Wakefield points out. “It’s the crew that sets up heavy equipment, camera operators who hold gear on their shoulders, technicians who work with small dials and wind up with carpal tunnel syndrome. Guitar players get frozen shoulders. Dancers need full body stretches. Acrobats may have a fall.”

“It’s a wide variety,” she says, “but I see more carpal tunnel than anything else.”

Technicians certainly get it, but so do drummers and guitar players. Many patients also seek relief from headaches that result from stress and fatigue.

The perks are notable. Obviously, Wakefield meets veritable bright lights in music. But she also gets to sample the five-star catered meals that tour workers are served. And she gets to see concerts for free. That’s a double bonus: a perk and an ego boost.

“Working with these people and then seeing them perform, you get a sense of pride,” she says. “You know they’re on top of their performance because you helped them.”

When Wakefield travels with acts, her colleagues at her clinic, Awaken Therapies, hold down the fort. She opened the business in 2008 because although the tours and concerts pay well, they’re sporadic. The clinic helps build a regular clientele.

How did she come to have this star-studded career? About 13 years ago, Wakefield happened to meet a concert road manager. Always looking for potential new clients, she asked if any of his contacts needed massage therapy. It did not take long before she was providing therapy to famous musicians and their crews. Those initial jobs went well and referrals have carried her along since then.

Wakefield doesn’t see herself focusing on the music industry forever. Her passion is sports massage therapy. She currently supports the men’s volleyball team at the University of Alberta’s Augustana campus in Camrose.

“My ultimate goal is to be part of the Olympics,” she says.
**Massage for top athletes**

Jason White, RMT, and head of Jason White Therapy in Toronto, seems to be living Wakefield’s dream. He is the athletic therapist for National Hockey Canada’s Sledge Program and the Ontario Sledge Hockey Program. He has been head athletic therapist for the Ontario Senior Women’s Rugby Division. He has also been the athletic therapist for Rugby Canada’s men’s and women’s teams. In 2013, he was a member of the Summer Canada Games core medical team.

White’s original training is athletic therapy (AT). Initially, he was working with provincial teams and recreational clubs, building up his network to eventually provide AT services to outfits playing at national levels. After a few years, he decided to become a massage therapist as well to broaden his skills and his client base.

Having both the AT and the RMT designations helps set him apart.

“In Canada right now, only five of us practice athletic therapy and massage,” White says. “So I don’t position myself as only a RMT when these jobs are contracted out. The teams want a well-rounded health professional with a full range of experience.”

His athletic-focused career is a natural fit considering his personal sport history. White was a competitive swimmer from the age of 10. He went on to compete at the provincials and varsity levels.

“I had my own injuries and sprains that needed treatment,” he says. “Meeting the therapists who helped me, I thought, ‘This is something I’d be interested in doing.’”

Athletes constitute a special class of patient compared to non-athletes.

“The rehab process differs,” White says. “It occurs at a faster pace and the recovery is a bit speedier. It’s their job. They work for national teams. They have full access to all the treatments available to them, full-time, as opposed to an office worker who maybe sees you once or twice a week for six to eight weeks and has other commitments.”

White’s reputation as an elite sports therapist pays off when it comes to building his business.

“When people call, they don’t necessarily ask for me by name, but they want the therapist who works with Rugby Canada and Sledge Canada.”

**“You know they’re on top of their performance because you helped them.”**

**Picture this RMT on set**

Alexandra Lynch, RMT, may be known as the therapist who has worked on films such as the K-19: The Widowmaker (starring Harrison Ford) and Amelia (with Hilary Swank). Owner of Stage Hands Massage Therapy in Halifax, she focused on film and TV while building her practice.

When Lynch and her business partner Cathy Tanner graduated from ICT Northumberland College in 1999, they wanted to establish a unique mobile massage therapy clinic – a service for the various actors and crews who used to flock to Nova Scotia to film. Lynch was interested in the industry, having done some amateur acting in the past.

“No one had gone after that niche. I had a couple of connections, and it grew from there by word of mouth.”

Tanner left Stage Hands in 2008, but Lynch has successfully carried on. She brings her portable massage table, linens and lotions to convenient locations for clients. That’s important for high-profile actors, she says.

“They don’t really want to be out in public visiting a clinic,” Lynch notes.

Her work is transferable, too. Her clients have been in penthouses, hotel rooms and movie trailers.
You try fitting a massage table into a movie trailer. It’s not as easy as it might sound.

In some respects, her clients are different from those of most other therapists. “Many actors are really well cared for and they know how to look after themselves, because their physical wellbeing is their livelihood.”

But in other ways, the stars are no different from anyone else. As Lynch says, “it doesn’t matter if you’re making $10,000 a year or $10 million a picture. When you’re on the massage table, you are at the most vulnerable and the most who you actually are.”

Until recently, about 50 per cent of her business came from the film and TV industries. But that started to wane about a year ago, after the Nova Scotia government changed the province’s film tax credit system, replacing a $24-million program with a much smaller $10-million one that covers fewer costs and makes Nova Scotia a less attractive filming location than it used to be.

What’s next now that the film industry isn’t as strong? Lynch says she is building a base of clients among people who have chronic illnesses and mobility challenges. Her practice is completely mobile, so she has no trouble bringing therapeutic know-how to individuals who would benefit from it, but have trouble getting to a traditional clinic.

“That has kept me busy,” she says.
Thank you Attendees, Speakers and Vendors!

Here's what some of the attendees had to say about our 2016 event:

“IT was a great day full of inspirational speakers. The one thing I took away from the forum was determining my goals. Setting the goals and making a plan to achieve them.”

“I enjoyed myself the whole time. All the speakers were interesting and did a great job presenting their material.”

“A big thank you and congratulations to all that were involved in making the event a big hit for me.”

“Had a great day at the Forum, this was my 2nd time. Overall, very happy to attend, the price is very reasonable. It's very refreshing to go to something that is reasonably priced, they feed you and you leave with 4 CEUs. I will definitely continue to attend in future.”

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In 2010, a patient of mine was diagnosed with bilateral venous insufficiency. At the time, she was prescribed a general topical cream to aid in decreasing the swelling and discoloration that was already occurring in her lower legs.

The cream proved to be of no help and, after stopping usage, she began – and is still, currently – taking hydrochlorothiazide to control the swelling.

In 2015, after no change in the lower legs, she was referred to a vascular surgeon at the Ottawa Civic Hospital for consultation and surgery. At this point in time, my patient thought surgery was her only option for treatment. Fortunately, the surgeon thought otherwise, and referred her for massage therapy – specifically, lymphatic drainage.

Chronic venous insufficiency (CVI) results from inadequate venous return over a long period of time. Many factors can contribute to decreased flow, but venous distension generally develops in females who habitually stand for long periods of time, cross their legs at the knees, are overweight or have had previous leg injury or surgery. These factors can lead to inflammation of the local tissues and vessels, resulting in chronic pooling of blood in the veins of the lower extremities.

Assessment
Some of the classic presentation and symptoms of CVI include: swelling in the lower leg; hyperpigmentation of the skin in the affected area; decreased range of motion at the knees and/or ankles; and pain and discomfort with prolonged standing. CVI can affect one or both legs.

Upon initial assessment, the patient informed me that her doctor and surgeon cleared her of any underlying medical conditions or embolisms that could affect treatment. After reviewing her initial intake forms and discussion, we noted that the swelling in her lower legs began one year after having double knee replacement. In addition to this, she states that she stands for long periods of time cooking, taking only a few breaks, and with no use of compression stockings.

Palpation and visual assessment showed: increased muscle tension through bilateral quadriceps and hamstrings; bilateral vertical healed scars over anterior knee joint; increased swelling through bilateral lower leg and ankle; and deep red to purple colouring of skin covering the lower aspect of both legs and ankles, anterior and posteriorly.

Range of motion testing at the knees proved to be normal, but movements through both ankles were limited. My client reported increased pain with increased palpation pressure. Swelling was non-pitting edema.

Treatment Plan
Measurements of both lower legs were taken pre- and post-treatments to track the changes in swelling and tissue. Using a soft tape measure, we tracked the girth where swelling was most prominent – at the belly of the gastrocnemius.

Measurements were taken while the patient was prone. Initial measurements pre-treatment were: right leg 45cm, and left leg 44cm.

We decided that treatment would be received once a week for four weeks. It would include: hydrotherapy to the inguinal lymph nodes; elevation of legs; nodule pumping at the terminus and proximal lymph nodes; short, soft strokes moving fluid proximally while working...
distally; and soft tissue release of tight muscles where swelling was not a factor.

Overall, this treatment was aimed at decreasing swelling, improving blood flow back to the heart and increasing range of motion.

In addition, I decided to give my patient home care exercises to do in between treatments to help improve her symptoms. These home care assignments consisted of: elevation of the legs for 20 minutes at the end of each day; regular breaks from standing throughout the day; ice to affected areas when painful; and the use of compression stockings.

OUTCOMES
After two weeks of treatment and home care exercises, positive changes were occurring and being reported by the patient.

By the four-week mark, my patient reported no pain through her legs. She stated that she was able to stand for long periods of time – more than one hour – in the kitchen, with no pain or increased swelling. She reported that her legs felt lighter and thinner.

Discolouration of the lower legs had also decreased, but was still an issue. Upon remeasurement of the lower leg, the swelling had decreased significantly. The right leg now measured at 42.5 cm (from 45 cm pre-treatment) and the left leg measured at 41 cm (from 44 cm pre-treatment) – a significant improvement for the patient.

Following the four-week mark, we extended treatment and reduced the frequency to once every two weeks. We did this for the next two weeks.

Measurements of the lower legs stayed the same as they had at the re-assessment at four weeks, and pain for my client was no longer an issue.

Home care exercises remained the same, with the addition of stretching through the gastrocnemius and ankle joint.

Currently, treatment has been further reduced to once every three to four weeks, to maintain tissue health, proper blood flow and range of motion.

This was a life changing treatment for my patient, who initially thought she would have to live with the pain and swelling for the rest of her life.

Massage therapy and lymphatic drainage proved to be very beneficial for her and her condition. I am pleased to say that she has a newfound love for massage therapy – and her legs.

Lymphatic draining is a simple and gentle, yet highly effective treatment.

Chronic venous insufficiency generally develops in females who are overweight or habitually stand for long periods of time.
While corresponding to the shoulder in terms of position and joint type, hip conditions and treatment differ from the shoulder. Both attach the extremity to the torso and both are ball and socket joints. However, beyond that, they differ profoundly.

The hip is weight bearing with a deep ball and socket joint. The muscles and ligaments that surround it are strong and the joint is stable. Dislocations are rare. If they occur it is usually associated with motor vehicle accidents, where the flexed femur is violently thrust posteriorly as the knee is jammed against the dashboard. Muscle strains are common. Describing these in detail belong in another article since they are potentially complex, albeit interesting, topics.

Common hip conditions this article will address are trochanteric bursitis, impingement and arthritis. Arthritis (in this instance osteoarthritis) is the “wear and tear” effect of inter alia advanced age, poor mechanics, physical trauma and congenital predisposition. Signs and symptoms include pain in the groin, thigh, buttock, hip, back and even pain referred to the knee. Pain with initial movement usually abates with motion as the consequent flow of synovial fluid nourishes the joint surfaces. Other complaints include decreased range of motion (ROM), joint stiffness and possibly a “crunching” sensation in the hip.

Hip impingement may mimic osteoarthritis in that it is also typified by loss of ROM and discomfort at certain ranges but may otherwise be symptomless. Contrary to what one might believe, joints are not fully congruent. Movement between the joint surfaces, known as accessory movements, actually augment the gross movement of the joint itself. The loss of accessory movement is the mechanical cause of impingement. All too often, well meaning therapists continuously stretch muscle in the futile hope that they will augment range of movement. In actual fact, the decreased range may be an articular phenomenon, the joint kinematics are not working properly. Whether one is assessing hip arthritis or impingement, in both instances a useful diagnostic tool is hip scouring.

Scouring involves passive movement of the hip by the therapist through all ranges emphasizing the periphery where the femoral margin impacts on the acetabulum. The therapist must note where pain occurs since treatment will be position-specific. One must also be mindful of the fact that the L2 and L3 scleratome, which innervates the hip, refers pain to the anterior and medial thigh. Resisted tests for the hip create pressures within the hip joint, which may prompt pain sensations in the thigh as described. Hence,
A tight ITB is a misnomer; it’s a tight gluteus maximus muscle that must be addressed.

the therapist can be misled into thinking it is a contractile injury. Scouring the joint, which is passive, will obviate this confusion.

**IMPPINGEMENT**
An invaluable treatment tool for impingement is hip mobilization. The significant change in range and comfort due to mobilizations will differentiate impingement from arthritis. Hence, it is also a useful assessment tool. This will indicate, if symptoms do not change, that further treatment is required directed at arthritis.

By doing distraction, and anterior and posterior mobilizations, you will reintroduce the accessory movements thereby normalizing the joint kinematics. With ball and socket joints, the convex surface slides along the concave surface, in the opposite direction of the joint’s movement, i.e. if the joint is rotating up, the convex surface is sliding down.

In these pictures you see distraction, and posterior glide, both done supine. With distraction it’s wise to have the tibia placed over your shoulder to facilitate using your body for leverage – particularly useful if your patient is bigger. Position prone for anterior glide. Ensure you have the hip slightly flexed to avoid closed packed position. Usually, up to six repetitions into high-grade mobilizations will suffice.

**ARTHRITIS**
Arthritis is best treated with articular pumping, as taught by the French osteopath, Guy Voyer. This follows the premise of stimulating synovial fluid through a pumping action. As stated, movement stimulates synovial flow at the joint surfaces as the articular cartilage compresses and decompresses – hence, the decrease in symptoms with motion that patients describe. Articular pumping amplifies the compression and decompression effect tremendously, with the result being that the joint gets a mega dose of synovial fluid and nourishment.

With this technique, the patient does very gentle isometric contractions in a certain direction, e.g. hip flexion, but it may be necessary to include abduction, extension and adduction. Resistance is very light, merely enough to indent the pad of your securing fingers. The patient holds his/her breath for five seconds as they contract. The patient then exhales as the therapist distracts the joint for five seconds. A third five-second passive phase follows for both therapist and patient. Do at least four repetitions, though sometimes up to 20 may be necessary. For resolution, possibly include a host of positions to address the entire joint, e.g. deep flexion, adduction and abduction as illustrated in the pictures.

**TROCHANTERIC BURSITIS**
Trochanteric bursitis presents as burning pain in the lateral pelvis. Inter alia wide pelvis, cambered walking/running surface, step/hill running, unequal leg length and an inominate positioning lesion (upslip, downsip, rotation) are all contributing factors. Significantly, and usually neglected, is the ilio tibial band (ITB) – the gluteal relationship. All too often, therapists focus on the ITB and neglect the gluteus maximus, which is the primary contractile component of this chain. The gluteus maximus is a powerful muscle that governs a myriad of thrusting, lunging movements typical of lower extremity sports and daily activities. Simply put, if the gluteus maximus is chronically restricted, the ITB constricts, which in turn rubs against various boney protuberances – the greater trochanter as well as the femoral lateral epicondyle (ITB friction syndrome) and tangentially will affect the patella femoral relationship (PFS syndrome) via the lateral patellar ligament /lateral vastus transverse fibers.

A “tight ITB” is a misnomer. It is a tight gluteus
maximus muscle that must be addressed. The tensor fasciae latae (TFL), while attaching to the ITB anteriorly, plays a less significant role. It is smaller and does not perform the same powerful closed chain movements of the gluteals.

Traditionally, the treatment of choice would be to stretch the gluteal muscles. The problem is the gluteals elicit movement over a single joint. It does not have the leverage of the hamstring, which – extending across two joints – allows one to use the hip and knee to maximize the stretch, as in a straight leg raise position.

Anecdotally, it is clear that the structure of the hip itself also limits flexion, with the femur approximating the acetabular labral lip likely before the gluteals experience any real stretch. A patient with a large abdomen further precludes a stretch into flexion.

Experienced therapists will note that, over time, chronically constricted muscles develop restricted fascia. Often it’s the status of this fascial tissue that determines how “tight” the muscle is.

To obviate the discussed shortcomings of stretching the gluteals, direct fascial release of this muscle is a good alternative, especially since fascial work could be considered to result in a more permanent response on the tissue. By palpating the inferior posterior margin of the ITB, the therapist will have a good sense of the tissue’s restricted status.

Aside from the patient’s feedback, palpating the tissue before and after treatment is an ideal way of determining the success of the technique.

By engaging the elastic quality of the gluteal fascia, slowly challenge its plastic resistance and progress slowly laterally. The patient may feel a profound pull. However, as you persevere and the tissue releases, this sensation will abate.

Work at the speed the tissue allows. It’s a process, and takes patience and practice. Working slowly enables body fluids to disperse, and minimizes the possibility of bruising.

Although subsequent treatments may be necessary, the patient will feel the change after even one application. The therapist will note the change with the ITB in palpation as well.

Released gluteal fascia will result in an unrestricted ITB which then presses less on the greater trochanter. By the same token, this is an ideal modality to treat ITB Friction syndrome and plays a tangential role in treating PFS.

While these techniques are ideally explored in a hands-on teaching environment, this article aims to assist the therapist in understanding these conditions. It also introduces the reader to these practical modalities that treat these conditions successfully.

More articles on techniques and modalities can be found on www.massagetherapycanada.com
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[Resource Directory]
What you say can be used against you  

BY JESSICA FOSTER

Have you ever visited a website or social media site, posted a comment or a picture that you assumed would be either private or not associated with you? Just as a wearable fitness tracker stores information about you; the web stores a whole lot more information about you and your online activity. If you think what you post on the web is not traceable or reproducible, think again. Your smartphone, computer hard drives, websites visited, social media platforms and the like, keep meticulous records of your online activities, all traceable to you.

Businesspersons, including allied health-care providers, routinely use good judgment to filter their daily interactions and communications with clients and colleagues. But for some people, that filtering goes right out the window when spontaneously tweeting or posting to web-based platforms. That’s never a problem – until it is.

In the winter of 2016 a Facebook post resulted in a Saskatchewan nurse facing charges of professional misconduct by the Saskatchewan Registered Nurses’ Association. The nurse reportedly posted a statement that some RNs needed refresher courses in giving quality-of-life-oriented health care to the elderly. While this seemingly innocuous sentiment may appear to be innocent enough, that doesn’t change the fact she was charged with professional misconduct by her nursing association.

Did you know that website and social media sites are regularly scanned and archived in databases? That means that changing or deleting your posts and content doesn’t mean they are gone. Check out www.archive.org to view monthly, historical versions of virtually all sites on the Internet that are viewable and completely recoverable by anyone.

**Digital accountability**

There is a brave new world of opportunities afforded by online applications and educational material that connect caregivers, their clients and the general public. This offers an incredible opportunity for RMTs. There is a phenomenal benefit derived from contributing, responsibly exchanging and studying clinical related content and promoting quality health care for clients and practitioners alike.

Just remember that both your personal and professional digital tracks are easily tied together. RMTs – especially regulated RMTs – need to regularly review and re-assess their approach to social media sharing to ensure they are engaging in the positive side of these interactions.

Always consider the dangers of creating content, posting or responding to comments on the web. This does not mean you should not actively participate in personal and professional social media information exchanges. It just means you want to think twice before putting your thoughts out there, where they may live forever. Review your messaging using some common sense filters before hitting the post button. Consider just a few filtering rules of thumb:

Because your professional image is associated with your personal image, ask yourself if your online activity promotes professionalism.

If your post is related to health care, does your commentary fit into your scope of practice, and is it accurate and useful?

If personal, does the post also portray you as the professional that you are?

Remember, dissemination of copyrighted material without permission is a big no-no.

Health Information posted that can identify a patient, whether or not by name, should be avoided at all cost.

Your online “footprint” is not just information you have posted. It includes information that others have posted that includes you. Some people think their comments in closed group social sites are not available to the public. There are over a dozen Dalhousie dental students who learned the hard way that any member can take screenshots of what is said (or not said) by other members in the “closed-group” and disseminate it to a global audience.

You might be surprised at how much information can be discovered by anyone with an agenda to uncover your background. Standards for professional interactions between your clients and potential clients should be consistent across all your forms of communications, whether personal or professional.

While the vast majority of RMT’s will benefit greatly from the increase in clinical and professional social media information exchange with clients and colleagues, it may be helpful to remember to filter both what you read and what you say.
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