Treating sport-specific

Sports massage techniques for common overuse injuries
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Cómo llamar la atención sobre la información falsa

Cómo calificar que dictionary.com’s “Palabra del Año” es “información falsa.”

Estuve sorprendido y a la vez me enojé. Si eres un terapeuta de masaje y/o defensor de la profesión de masaje, entonces me imagino que has sentido las mismas emociones que yo mientras leía el artículo reciente de Green Shield Canada: “El elefante en la (espera) habitación.” (Según el tiempo de impresión, el artículo aún estaba disponible en el sitio web de la compañía, aunque se retira.)

El artículo es un acompañamiento a un comunicado de prensa del 5 de octubre, titulado: “Hemos gastado más en masaje que en servicios de salud de la mentalidad...”. El artículo presenta un nuevo plan de beneficios que incluye el masaje como una opción de beneficio para facilitar el acceso y la consistencia de atención de cuidado, (y entre otros). ¿Un oversight? Como verás en la página 6, uno de los objetivos de la RMTAO Queen’s Park Day fue visitar con los MPPs y discutir el rol del MT en abordar los síntomas físicos de salud mental, así como en el largo plazo y para el cuidado de los mayores, entre otros. ¿Un oversight?

El artículo también está acompañado de un comunicado de prensa del 5 de octubre, titulado: “Hemos gastado más en masaje que en servicios de salud de la mentalidad...”. El artículo presenta un nuevo plan de beneficios que incluye el masaje como una opción de beneficio para facilitar el acceso y la consistencia de atención de cuidado, (y entre otros). ¿Un oversight? Como verás en la página 6, uno de los objetivos de la RMTAO Queen’s Park Day fue visitar con los MPPs y discutir el rol del MT en abordar los síntomas físicos de salud mental, así como en el largo plazo y para el cuidado de los mayores, entre otros. ¿Un oversight?

La serie de errores, el artículo presentado por la no-for-profit proveedor de beneficios utilizó tácticas de manipulación para persuadir a los lectores a dar más importancia a sus beneficios de masaje que a las medicinas que un empleado necesita. El artículo “supone que dijo sí,” y luego continúa disminuyendo los beneficios de terapia de masaje – diciendo que, en realidad, es menos relajante y es de algún modo “just as good as a nap”.

Seriosamente, hay un buen motivo (o un multitud de razones) para decir que el masaje es uno de los beneficios de empleo más importantes. Desmentir el masaje y declarar que el masaje no es importante es fastidioso.

Sólo unos días después de que este artículo fue publicado, los MTs de todo el país se pasearon, reaccionaron, compartieron y compartieron el artículo (y todas sus) malas acciones con sus clientes, la industria, y con el original autor.

Kudos a la RMTAO y a la Canadian Massage Therapy Alliance por hacer un buen trabajo con esta situación – ellos ya han preparado el terreno con Green Shield Canada’s representative el tiempo que le diste.

Nos comunicamos con Green Shield para comentar. Les dijimos que la compañía está “hablando con la RMTAO...” y que vamos a continuar con el diálogo.

Les llamo a todos los terapeutas de masaje del país para llamar la atención sobre la información falsa cuando la vean. Una voz se convierte en muchas.

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Después de recibir tu aprobación para estos documentos, asegúrate de que estos documentos cumplan con tus necesidades y estés responsable de cualquier error después de tu aprobación.

JANNEN BELBECK, Editor

Usa la etiqueta de hashtag #MassageTherapyCanada para tener la oportunidad de aparecer en un futuro Issue!
If you have ever felt a desire to expand your skill set in order to offer your patients more treatment options, consider a future in osteopathy!

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New guidelines suggest women who are physically active throughout pregnancy can boost their mental health and reduce the risk of gestation-related complications. The research-based guidelines show regular exercise can cut the risk of such illnesses as depression by 25 per cent and the risk of gestational diabetes, high blood pressure and pre-eclampsia by 40 per cent. The guidelines encourage pregnant women without medical restrictions to accumulate at least 150 minutes of moderate-intensity physical activity over a minimum of three days per week.

ICYMI

Have you heard?

Lounging around all weekend may weigh heavy on the minds of the health conscious. But these sedentary stretches may not affect the waistline, provided they’re preceded by a bit of exercise. A new study from UT Southwestern Medical Center shows neurons in mice that influence metabolism are active for up to two days after a single workout. The research offers new insight into the brain’s potential role in fitness and – in the longer term – may provide a target for developing therapies that improve metabolism.

PREGNANCY

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METABOLISM

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THE REGISTERED MASSAGE THERAPISTS’ ASSOCIATION OF ONTARIO (RMTAO) held their first-ever Queen’s Park Lobby Day on November 26, 2018. This event was an opportunity to meet with Members of Provincial Parliament (MPPs) from all political parties to discuss the benefits of massage therapy and the role that massage therapists can play in health care.

Robin Martin, one of the Parliamentary Assistants to the Minister of Health and Long-Term Care, spoke about increased funding and support to treat mental health and addictions, and saw a role for massage therapy in the treatment of chronic pain and mental health associated with the provincial opioid crisis. France Gélinas, the NDP Health Critic, also spoke to the RMTAO about massage therapy in hospice, home care, seniors’ care and long-term care. The MPPs were extremely enthusiastic and supportive, offering to attend massage therapy events in their ridings, champion the inclusion of massage therapy in relevant government health initiatives, and act as a liaison between the RMTAO and key policy makers and researchers.

The RMTAO received many requests for additional meetings with MPPs, Ministers and key committee members. In particular, RMTAO will be approaching new partnerships with seniors’ care policy groups, consulting with a member of the committee that will be examining the evolution of the Auto Insurance Benefit and the Statutory Accident Benefits Schedules (SABS), and connecting with the chair of the Premier’s Council on Improving Healthcare and Ending Hallway Medicine. — RMTAO

Always advancing

RMT Dave Filice, owner of Full Motion performance and recovery in Ancaster, Ont., understands the importance of constantly improving your practice with continuing education.

“Spent the last week at James Waslaski’s Integrated Manual Therapy and Orthopedic Massage, learning the latest manual therapy protocols to eliminate pain and sports injuries. Can’t wait to start applying these techniques in my practice.”

TOUCH POINTS

INDUSTRY

RMTAO’s First Queen’s Park Day

The registered massage therapists’ association of Ontario (rmtao) held their first-ever Queen’s Park Lobby Day on November 26, 2018. This event was an opportunity to meet with members of provincial parliament (mpps) from all political parties to discuss the benefits of massage therapy and the role that massage therapists can play in health care.

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THIS MONTH’S TOP STORY ONLINE

Fighting fraud: Read it now at https://bit.ly/2rrVQFq
**PRODUCT**

Meditation support

The yogi masters were right: Meditation and breathing exercises can sharpen your mind. Research out of Trinity College Dublin this year explained the neurophysiological link between breath-focused meditation, and attention and brain health, finding evidence “to support the view that there is a strong connection between breath-centred practices and a steadiness of mind.”

While more and more research touts the benefits of meditation for the relief of stress, anxiety, and emotional health (among others) there are some people who just don’t find the practice very comfortable. Enter OmBase, a Canadian start-up that manufactures meditation benches and accessories. The OmBase, a lightweight meditation support bench, can help those with pain and discomfort better manage their meditation practice. The device is fully adjustable between three and nine inches – useful for both cross-legged and kneeling positions. Even the seat pad itself is adjustable. The user can choose between a flat seat or a surface tilted slightly forward.

The OmBase can also be used in place of yoga blocks during practice, and when flat, as a headrest or lumbar support. Weighing in at only 3.25 pounds, it can be carried around using the strap, or placed in your backpack or bag. Visit ombase.ca to learn more.

**PATIENT CARE**

Can’t exercise? A hot bath may help improve inflammation, metabolism, study suggests

**Hot water treatment may help improve inflammation and blood sugar (glucose) levels in people who are unable to exercise, according to a new study. The findings are published ahead of print in the *Journal of Applied Physiology*.**

Physical stress such as exercise can cause the short-term elevation of inflammatory markers. After exercise, the level of an inflammatory chemical (IL-6) rises. In a process called the inflammatory response, this activates the release of anti-inflammatory substances to combat unhealthy high levels of inflammation, known as chronic low-grade inflammation. Recent research has shown that raising body temperature augments the inflammatory response and provides a rationale for identifying exercise alternatives that reduce low-grade inflammation in the body. Previous studies have also found a connection between a spike in body temperature and nitric oxide production, a substance that aids blood flow and helps carry glucose throughout the body.

Researchers studied markers of inflammation and blood sugar and insulin levels in a group of sedentary, overweight men. The volunteers participated in both hot-water immersion and ambient room temperature (control) trials separated by at least three days. The researchers took blood samples before and after the participants rested in an 80 F (26.6 C) room for 15 minutes. After the rest period, the participants either remained seated in the room or entered a hot-water bath for 60 minutes. In the hot water trial, the volunteers sat immersed up to their necks in 102 F (38.9 C) water. The research team measured the men’s heart rate, blood pressure and body temperature every 15 minutes throughout both the control and immersion conditions. Blood samples were taken again two hours after each session.

The researchers found that a single hot-water immersion session causes the elevation of IL-6 levels in the blood and increased nitric oxide production, but did not change the expression of heat shock protein 72 – another protein suggested to be important for health. However, a two-week treatment period in which the men participated in daily hot-water baths showed a reduction of fasting blood sugar and insulin levels as well as improved low-grade inflammation at rest.

The men reported a level of discomfort during the hot water immersion trial, which could be due to the high temperature of the water or the length of time they were required to remain immersed. The researchers acknowledge that these conditions may make it difficult for people to commit to this type of alternative treatment. However, the positive results of decreased inflammation and improved insulin sensitivity suggest that hot-water immersion may “improve aspects of the inflammatory profile and enhance glucose metabolism in sedentary, overweight males and might have implications for improving metabolic health in populations unable to meet the current physical activity recommendations,” the researchers wrote — American Physiological Society.
RESEARCH

How exercise could help fight drug addiction

The siren call of addictive drugs can be hard to resist, and returning to the environment where drugs were previously taken can make resistance that much harder. However, addicts who exercise appear to be less vulnerable to the impact of these environmental cues. Now, research with mice suggests that exercise might strengthen a drug user’s resolve by altering the production of peptides in the brain, according to a study in the journal ACS Omega.

Re-exposure to drug-related cues, such as the location where drugs were taken, the people with whom they were taken or drug paraphernalia, can cause even recovered drug abusers to relapse. Prior studies have shown that exercise can reduce craving and relapse in addicts, as well as mice. Although the mechanism was unknown, exercise was thought to alter the learned association between drug-related cues and the rewarding sensations of taking a drug, possibly by changing the levels of peptides in the brain. Jonathan Sweedler, Justin Rhodes and colleagues at University of Illinois at Urbana-Champaign decided to explore this theory by quantifying these peptide changes in mice.

Mice were given cocaine injections over four days in special chambers with a distinctive floor texture to produce a drug association with that environment. The animals were then housed for 30 days in cages, some of which included a running wheel. The researchers found that mice that exercised on these wheels had lower levels of brain peptides related to myelin, a substance that is thought to help fix memories in place. Re-exposure to the cocaine-associated environment affected running and sedentary mice differently: Compared with sedentary mice, the animals with running wheels showed a reduced preference for the cocaine-associated environment. In addition, the brains of re-exposed runners contained higher levels of hemoglobin-derived peptides, some of which are involved in cell signaling in the brain. Meanwhile, peptides derived from actin decreased in the brains of re-exposed sedentary mice. Actin is involved in learning and memory and is implicated in drug seeking. The researchers say these findings related to peptide changes will help to identify biomarkers for drug dependence and relapse.

— American Chemical Society

25 years of service

As the CSMTA moves into its 32nd year in 2019, 25-year certificates were presented to Geraldine Barrett, Aurel Hamran and Ed Ratz this year. Pictured here L-R: Monty Churchman (Vice President, CSMTA), Geraldine Barrett (recipient), Aurel Hamran (recipient), Jessica Sears (President, CSMTA).

Finding her niche

CCMH Cambridge campus alumn Natiely Lai (pictured here in the blue sweater), recently spoke to a few students about her experiences in the profession after graduation.

“We caught up with one of our active alumni, Natiely Lai, who spoke about how she was able to fill a niche specializing in massage therapy for athletes and boxers.”

It’s a stretch

Erin Skitch, RMT at Complete Health & Performance in Ajax, Ont., poses with friends as they wrap-up a course.

“What an amazing week! Just wrapped up Fascial Stretch Therapy Level 1 with these beauties! Stay tuned to see what FST is all about.”

Time for regulation

A reply to the CBC news article "Harassment, sexual requests part of a day’s work, says Calgary massage therapist”

“I come from Ontario. A safe, professional and regulated province. What an eye-opener it was to move here. Alberta has been fighting to be confirmed as a regulated health profession in massage for YEARS. I have had friends fall victim to the lack of regulation had people make sexual jokes about my job.”
RESEARCH

Pain can be a self-fulfilling prophecy

Expect a shot to hurt and it probably will, even if the needle poke isn’t really so painful. Brace for a second shot and you’ll likely flinch again, even though the second time around you should know better.

That’s the takeaway of a new brain imaging study by University of Colorado at Boulder neuroscientists, who found that expectations about pain intensity can become self-fulfilling prophecies. Surprisingly, those false expectations can persist even when reality repeatedly demonstrates otherwise, the study found.

“We discovered that there is a positive feedback loop between expectation and pain,” said psychology and neuroscience professor Tor Wager, senior author of the paper published in *Nature Human Behaviour*. “The more pain you expect, the stronger your brain responds to the pain. The stronger your brain responds to the pain, the more you expect.”

For decades, researchers have been intrigued with the idea of self-fulfilling prophecy, with studies showing expectations can influence everything from how one performs on a test to how one responds to a medication. The new study is the first to unpack the vicious cycle between increased pain expectations and increased pain and elucidate the neural mechanisms underlying it.

Marieke Jepma, then a postdoctoral researcher in Wager’s lab, launched the research after noticing that even when test subjects were shown time and again that something wouldn’t hurt badly, some still expected it to.

“We wanted to get a better understanding of why pain expectations are so resistant to change,” said Jepma, lead author of the study and now a researcher at the University of Amsterdam.

The researchers recruited 34 subjects and taught them to associate one symbol with low heat and another with high, painful heat. Then, the subjects were placed in a functional magnetic resonance imaging (fMRI) machine, which measures blood flow in the brain as a proxy for neural activity. For 60 minutes, subjects were shown low or high pain cues (the symbols, the words Low or High, or the letters L and W), then asked to rate how much pain they expected.

Then varying degrees of painful but non-damaging heat were applied to their forearm or leg, with the hottest reaching “about what it feels like to hold a hot cup of coffee” Wager explains. Then they were asked to rate their pain.

Unbeknownst to the subjects, heat intensity was not actually related to the preceding cue. The study found that when subjects expected more heat, brain regions involved in threat and fear were more activated as they waited. Regions involved in the generation of pain were more active when they received the stimulus. Participants reported more pain with high-pain cues, regardless of how much heat they actually got.

“This suggests that expectations had a rather deep effect, influencing how the brain processes pain,” said Jepma.

Surprisingly, their expectations also highly influenced their ability to learn from experience. Many subjects demonstrated high “confirmation bias” – the tendency to learn from things that reinforce our beliefs and discount those that don’t. For instance, if they expected high pain and got it, they might expect even more pain the next time. But if they expected high pain and didn’t get it, nothing changed.

“You would assume that if you expected high pain and got very little you would know better the next time. But interestingly, they failed to learn,” said Wager.

This phenomenon could have tangible impacts on recovery from painful conditions, suggests Jepma.

“Our results suggest that negative expectations about pain or treatment outcomes may in some situations interfere with optimal recovery, both by enhancing perceived pain and by preventing people from noticing that they are getting better,” she said. “Positive expectations, on the other hand, could have the opposite effects.”

The research also may shed light on why, for some, chronic pain can linger long after damaged tissues have healed.

Whether in the context of pain or mental health, the authors suggest that it may do us good to be aware of our inherent eagerness to confirm our expectations.

“Just realizing that things may not be as bad as you think may help you to revise your expectation and, in doing so, alter your experience,” said Jepma.

— University of Colorado at Boulder
Skillfully applied sport massage therapy can increase performance, decrease potential injury and assist the athletes’ mental preparations. The techniques require a skillful and appropriate application, as it can result in the difference between qualifying, winning, losing, or obtaining a personal best time or score for the athlete. Athletes have recognized the benefits of introducing regular sport massage into their regimens, as it reduces fatigue, promotes flexibility, improves endurance, helps prevent injuries and prepares their body and mind for optimal performance.

Sport massage therapy takes into consideration the sport-specific movements placed on the individual athlete for that sport. The sport massage therapist must be knowledgeable in the biomechanics and functional patterns of the specific sport in order to develop injury prevention strategies and treatment programs for the athlete.

Sports require a full range of motion from the joints, muscles and connective tissue that are critical to the movement being executed. Let’s look at the synergistic relationship between the shoulder and the scapula and how it relates to movement and sport.

The relationship of the humerus movement relative to the scapula is called the scapulohumeral rhythm. Limited mobility of the scapula can limit the three-dimensional movement of the shoulder complex, not allowing the scapula to clear the rotator cuff when raising the arm (Von Eisenhart. Clinical Orthop. Relat. Res, 2005.) Another key component related to the movement of the shoulder/scapula complex is the amount of mobility within the thoracic spine as reported by Tate A.J in an article published in the J.Athl.Train, 2012.

**RESTRICTED SCAPULAR MOVEMENT: RACKET SPORTS, VOLLEYBALL, SWIMMING**

Perhaps the greatest illustration of the balance between shoulder mobility and stability occurs during sports that require repeated overhead motion. Sports where overhead movement is required most include racket sports and volleyball, which require two or three overhead movement patterns. More overhead patterns are prevalent in swimming. These repetitive overhead movements can lead to repetitive strain injuries, alter mechanics that can result in poor performance for the athlete.

Scapular mobilization techniques are useful to increase scapular movement, which may deteriorate due to the change and release of adhesions in the scapulothoracic muscles. These techniques can lead to increase of accessory motion, increase range of motion at the shoulder complex, and improve periartricular muscle performance as described in the BMC Musculoskeletal Disorder, 2015 journal by Sharma SP.

Scapular mobilization procedures involve superior, inferior, medial and lateral glide with the athlete lying on the unaffected side. The athlete and therapist positioning are the same for...
all with a few changes in the hand placement to allow for the appropriate scapular mobilizations. (Figures A, B, C and D.) To begin, have the athlete side lying facing the therapist. The athlete’s arm is in a neutral position (shoulder and elbow flexed) and resting on the therapist’s arm. A pillow can be used as a barrier and for additional comfort, although it may restrict movement. All movements are to start in a grade 1 and gradually increase to grade 4 mobilizations as the athlete’s tolerance increases. Suggested parameters will vary, however eight to ten repetitions in each grade with a hold in each mobilization for three seconds is adequate, within the athlete’s tolerance. In order for these techniques to be effective, the athlete movements must be passive and the therapist must use the athlete’s trunk to provide the key force through the arms, to allow for appropriate movement in the scapulothoracic (ST) region for the mobilization to occur.

Superior/Inferior Glide (Elevation/Depression) – The lower hand is placed around the inferior angle of the scapula with the thumb and forefinger along the lateral and medial scapula borders. The upper hand grasps the spine of the scapula, cupping the heel of the hand anteriorly over the clavicle. The therapist will mobilize the scapula superior and inferior. Superior glide (Fig. A) will increase ST range of motion (ROM) and lateral rotation of the shoulder, whereas the inferior glide (Fig. B) will increase medial rotation of the shoulder as well as the ST ROM.

Medial/Lateral Glide (Protraction/Retraction) – The lower hand is placed around the inferior angle of the scapula with the thumb and forefinger along lateral and medial scapula borders. The therapist’s upper hand grasps the spine of the scapula, cupping the heel of the hand anteriorly over the clavicle. The therapist will mobilize the scapula medial and lateral. The medial glide (Fig. D) will increase ST joint retraction, depression and medial rotation and lateral glide (Fig. C) will increase ST joint protraction, elevation and lateral rotation.

RESTRICTED HIP MOBILITY: BASKETBALL AND SOCCER PLAYERS, RUNNERS

We can also look at a basketball player’s ability to pivot and jump, a runner and soccer player’s ability to propel the legs forward to achieve sufficient knee-drive during the sprint – all of these motions are impacted by the strength and flexibility of the hips.

Restricted hip mobility has shown strong correlation with various pathologies of the hip, lumbar spine and lower extremity, and can consequently continue to have effects not only at the involved joint, but throughout the entire kinetic chain. Any sport that requires squatting, pivoting, plant-and-cut motion and similar movements will involve hip flexion and internal rotation. Hip stability and mobility are key
components to create the speed and power production for sprinting, bounding, jumping, and agility movements. The main muscle groups responsible for propelling the body forward during running and jumping exercises are the quadriceps, hamstrings, and calf muscles. The hip flexor muscles may also contribute to these actions. In addition, the hip flexor muscles assist in bringing the free leg forward and upward during the recovery phase of running. An increase in hip flexion strength can help to improve sprint and agility performance for the physically active as well as untrained individuals.

Another favourite technique that high performance athletes often ask for is a hip flexor soft tissue release (Figures E and F). This technique can lead to increased mobility and range of motion in the hip, can help to decrease low back and knee pain and can increase core stability. The effects are also seen in the training room, with a potential increase of speed, strength and power in that athlete.

This technique is effective when you have access to ASIS and the structures around it. This hip flexion technique involves flexion and extension of the hip with one arm and soft tissue release with the other arm. To begin, the athlete is lying in a supine position and is close to the edge of the table to help with positioning and ease of technique. The therapist is treating on the same side of the athlete. A small amount of lotion can be used to reduce friction. Ask the athlete to assist with the movement of their hip and knee to 90 degrees. Once in the position, the therapist’s arm and hand will wrap under the athlete’s knee and therapist’s hand will rest on the athlete’s quadriceps. In turn, the athletes’ lower leg will rest on the therapist’s upper arm. The therapist’s body positioning will be facing the athlete at 45 degrees, and the therapist’s other arm will be placed on the athlete’s rectus femoris distal 1/3. The best starting position is to have the athlete’s hip at 70-55 degrees (Fig. E). As the therapist attempts to lengthen and straighten the athlete’s leg to neutral position with one arm, the other therapist’s arm has the tissue engaged and moving in superior direction towards the ASIS, on the athlete’s thigh and is applying moderate to deep pressure to perform a soft tissue release to the rectus femoris and other surrounding musculature (Fig. F). The pressure applied can be modified and accommodated to the athlete’s comfort level. Suggested parameters will vary. However, five to six repetitions will be effective to increase hip flexion mobility. The therapist can modify this technique throughout the hip flexion movement to incorporate ischemic pressure to release any trigger points or adhesion found along the route, as well as changing the frequency, depth and intensity to increase the results of the treatment. The technique can be treated in both passive movement (soft tissue release) as well as an active movement (active release technique).

As with any massage techniques, there are various modifications that can be used to correct and alter function and imbalances, and to prevent and correct biomechanical dysfunctions. A combination of massage therapy and mobilization integrated directly into the athlete’s fitness routine can make a difference in athletic performance. The two techniques described above are frequently used in my clinical practice, and have been successful in increasing on-field performance and reducing injury, both in training and during game-time.
CONTEMPORARY MEDICAL ACUPUNCTURE
Neurofunctional Treatment of Pain and Dysfunction

The McMaster University Contemporary Acupuncture Program has been teaching Neurofunctional Electroacupuncture to healthcare professionals for 20 years. Massage Therapists trained through the program have consistently achieved their goals.

The scope of the Program is beyond simple needle insertion; it provides the practitioner with a unique framework for assessment and treatment. The Neurofunctional Operating System has been shown to consistently generate clinical results above and beyond traditional treatment models.

The Contemporary Medical Acupuncture course at McMaster University was fantastic. It is an educational course that I will never forget. It forced me to open up my mind to new possibilities and has transformed the way that I approach my treatments. Dr. Elorriaga is an excellent educator and lecturer. His team of administrators and colleagues were extremely knowledgeable and imperative in the learning process.

Jessica Moore, RMT, Oshawa, 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尼斯et, 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 countess 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

The McMaster Contemporary Acupuncture Program meets the requirements of the College of Massage Therapists of Ontario Acupuncture Standard of Practice

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When you ask most massage therapists if they offer postpartum massage therapy, they usually answer quickly in the affirmative. Most of us are aware of the obvious presentations that follow giving birth such as extreme fatigue, back pain, edema, emotional fluctuations, etc. While those presentations are very common and often reported to us by our patients, there are other impacts that often go unspoken and therefore, untreated. One significantly impacted area for someone who has given birth is the pelvic floor. We believe providing postpartum massage therapy goes far beyond laying hands on a person who has given birth, into providing postpartum rehabilitation and education not always accessible to most of the public.

Pelvic health

The pelvic floor (PF) is a collection of muscles, nerves, tendons, blood vessels, ligaments and connective tissue interwoven in the pelvis. It extends from the pubic bone to the coccyx and the ischial tuberosities. During respiration it lowers and rises in synergy with the diaphragm.

The muscles of the pelvic floor consist of the pelvic diaphragm (levator ani muscle and coccygeus muscle), urogenital diaphragm (deep transverse perineal, sphincter urethrae), and the sphincters and erectile muscles of the urogenital and intestinal tract (external anal sphincter, bulbospongiosus, ischiocavernosus, superficial transverse perineal).

During pregnancy the uterus grows more than five times its original size and the load on the PF increases significantly, often causing symptoms of pain and altered function. There is an even greater load during the pushing phase of labour. In order for a full and accurate assessment of the PF, postpartum patients should see a pelvic floor physiotherapist who is able to access these structures internally and diagnose any dysfunctions that might exist. While it is not in our scope of practice to treat internal structures, we do have access externally to the musculature of key target areas. It is helpful for our work and to our patients to understand the role

BY MICHELLE FRANCIS-SMITH AND NICOLE NIFO

MICHELLE (B.A., RMT) and NICOLE (RMT) are the co-founders of Perinatal Massage Therapy Education. They inspire to empower and educate massage therapists with tools to more effectively and confidently work with perinatal patients. They provide continuing education courses in pregnancy, postpartum and infant massage, to help build your toolkit and increase your confidence to transform your perinatal massage practice and business. pregnancymassagetherapy.com
of pelvic floor physiotherapists and be able to offer a collaborative approach to care. “Working in collaboration has been a large benefit to patient care – especially continuity of care, when physios and RMTs work in the same clinic,” says Laura Apps, physiotherapist and owner of Women’s Health Physiotherapy Centre in Ajax, Ont.

“Most pelvic clients come to physiotherapy with many comorbidities. There is almost always external tension and an up regulated nervous system in a women who is seeking care for pelvic pain,” she says. “Having a trusted massage therapist to tackle the external drivers allows us to treat with greater success internally.”

Collaborating with physiotherapists who specialize in pelvic floor treatments provides a quicker recovery and return to optimal function of postpartum massage patients.

Postpartum cases

• Patient #1 – Six weeks postpartum, post cesarean section, experiencing mild numbness over her scar, increased muscle resting tension in upper and lower back and gluteals.

• Patient #2 – One-year postpartum, vaginal delivery, lower back pain and dyspareunia (painful intercourse), increased muscle resting tension in lower back, gluteals and adductors.

• Patient #3 – Eight weeks postpartum, previously an active runner. Obstetrician has given the approval to return to running. Patient is experiencing leakage of urine and general tightness in the hip flexors and quadricep muscles.

Best practices and recommendations

Always position your patient for safety and comfort. If a patient is post-vaginal delivery, all positions can be utilized based on preference. Avoid prolonged prone positioning immediately following delivery when core muscles are likely to be weakened. If a patient is post-cesarean delivery, prone positioning should be avoided for four to six weeks postpartum, or until the scar is unionized and the patient has no discomfort lying on their stomach. It is ideal to treat in side-lying, as there will likely be breast tenderness due to breast tissue changes from lactation.

We have developed a general protocol for how we treat our postpartum patients to address the PF. Using the three patient examples above, our approach remains the same. For the first few massage sessions, the goal is always to assess, palpate and treat the following target areas:

- Lumbar musculature (erectors, multifidus, quadratus lumborum, latissimus dorsi)
- Gluteal musculature (maximus, medius, minimus, piriformis, obturator internus, gemellus superior and inferior, quadratus femoris)
- Inner thigh (adductor minimus and magnus, obturator externus, pectineus, gracilis)
- Hip flexors (TFL, quadriceps, sartorius)
- Abdomen (rectus abdominis, external and internal obliques, psoas, iliacus)

Treatment planning for patients with a vaginal versus cesarean delivery

It is a great misconception among patients that those who have had a cesarean delivery will be free from pelvic floor dysfunction when compared to someone who has had a vaginal delivery. According to a study published by Almeida EC, et al. in the International Journal of Gynecology & Obstetrics (2002), in women with chronic pelvic pain, a history of cesarean section was observed at 67.2 per cent of cases.

For this reason, we suggest patients who have given birth in both cesarean and vaginal deliveries be assessed by a pelvic physiotherapist and given a pelvic floor rehabilitation program. Patients who have experienced a cesarean delivery should also be on a treatment plan to rehabilitate the scar.

Massage therapists are already equipped with the knowledge to treat the target areas most affected when pelvic floor dysfunction exists. By using the recommended guideline we have found that we can have a positive impact on reducing symptoms relating to pelvic floor dysfunction and improve the quality of our patient’s lives.

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When I was 16 or 17, I attended an outdoor leadership camp on Bark Lake near Madawaska, Ontario. Each night we chose electives to participate in, with the options ranging from tie-dye t-shirt making to amateur astronomy, to a shiatsu workshop. I joined the curious group in the introduction to Japanese massage. Sharon Gilmour, the woman who conducted the night began with this statement, “Massage is the greatest gift you can give somebody.” If I’d made a tie-dye t-shirt instead, who knows what my career trajectory would have been.

I had a lucky break, right from the get-go. My CMTO exam results had arrived in the mail on the same day that a friend phoned from the Dunnville Hospital. Pat Lane worked in accounts receivable and chummed with a gal in the X-ray department. “Jules, Nellie just broke her wrist – you should give her a call, right away.”

Nellie was the only registered massage therapist in Dunnville, a lakeside town of 5,000 near Niagara. I phoned Nellie and just like that, I took over her business. I had a full client load and six months later, Nellie never fully recovered from the fracture to practice again. I continued with her clientele until her lease expired and then moved into my own digs, The Upper Hand.

It was just the beginning of a resume that would see me employed at some of Toronto’s splashiest hotels: The Fairmont Royal York, King Edward, and even poolside at the Sheraton on Queen. I (happily) exhausted every possible placement short of travelling with the Cirque du Soleil. I worked at the wildly popular women-only spa, Body Blitz, did chair massage with the Great American Backrub and practised alongside chiropractors, naturopaths and even a sleep specialist.

It was an illustrious 17-year career that ended in the fanciest place possible, Langdon Hall Country House Hotel & Spa in Blair, Ontario. There were a few distinct perks here: being greeted by the hotel owners’ affable Bernese Mountain Dogs (Miss Wilks and Walter) each day and pretty much everything that Chef Jason Bangerter created in the galley. Being a massage therapist allowed me to work in some divine places (the kind I wanted to live in). I met Olympians, movie stars, NHL players, supermodels and even massaged a few horses for good measure. They say massage is portable, and it’s true – I took my hands to B.C. and worked at a spa, and explored equine massage and falconry among other things. Not massaging falcons, though. I don’t think that’s a thing.

This is what I’d pass along from my years in the trenches to the newbie ankle biters just getting started.

1. Be sure to continue to get massages, all kinds – whether you barter, trade or pay for them. With each one you’ll remember what it feels like to be on the table, and you might learn some new techniques, too.

2. I graduated in 1999 when social media was in its infancy. Print was still the traditional way to advertise a business. Even though I had Nellie’s caseload, I thought I would refine it at my new clinic: I paid $99 for a half-page ad in Hamilton’s Pink Pages. Hamilton was an hour from Dunnville, but still. I had one client who said, “I saw your ad in the Pink Pages.” Everyone else – word of mouth.

3. Try new things like building a lending library for your clients or sponsor a trail-run followed by a free stretching workshop. Some cities are saturated with therapists, so you
have to stand out and offer something distinctly different.

4. Establish what a reasonable workload is for you, and be sure to stick to that even when external pressures try to sway you.

5. If you’ve injured yourself, don’t be a champion and return to your massage schedule immediately. I certainly did and there was zero benefit to it – except for lingering facet joint issues and varicose veins from standing for so many hours in 17 years. Muscle has memory, but, it can also remember the wrong thing!

6. Find the snack foods that keep you alert and satiated. Although college promises that you can design your own hours and have picnics in the park midday, this rarely happens. Clients show up late and you end up chasing your entire day, sacrificing washroom breaks and eating.

7. Invest in a table warmer. There is nothing worse than a sub-zero treatment room (either due to winter drafts or arctic-level air conditioning).

8. Find a work environment that caters to your individual needs. If you want to focus on remedial exercise, treatment plans and in-depth intake interviews, hotel scheduling will clash with that. (The turn-around in-between clients can be five minutes!) If you have your own clinic, you can build in as much time as you deem realistic.

9. Keep refining your massage techniques into something that is both ergonomic and practical, while being result-driven. Depending on your size, don’t sacrifice your own body to achieve a stretch or deeper pressure for the benefit of a client. It’s never worth it. Instead, refer them to a colleague.

10. If you think it’s time to pack it in, it probably is.

For the entire duration of my massage career, I’ve had a sideline hustle as a freelance writer. I began writing routine book reviews for The Vancouver Sun and travel posts for the Matador Network. Canadian Running bought one of my stories and then I received a tweet from an editor at Mabuhay, the official in-flight magazine of the Philippines Airlines. I was offered a press trip with the Adventure Centre to blog about Cuba for two weeks, covered the Edmonton Folk Festival and Toronto’s food and drink scene for a tourism campaign. And, during this time, I was also writing this column, exploring crazy spa treatments around the world, profiling industry leaders and investigating topics like occupational allergies, salt caves and Lyme disease.

I was lucky enough to be able to patch two careers together and find satisfaction in both: Two years ago I became editor-in-chief of Harrowsmith, and discovered that when you sit down and take the time to write a book, you actually end up writing a book. My memoir, Free to a Good Home, will be published by Caitlin Press in March 2019.

While I’ve had a wild ride in this industry, I’m content to bring it to a close and officially retire from the profession.

Thank you for following me here and maybe I’ll meet you on your table one day soon.
COMMON POSTURES AND HOW THEY AFFECT THE LOWER BACK

(Common postures and how they affect the lower back)

In the normal posture (Fig. 12.8) the ear sits roughly over the shoulder, the shoulder sits over the trochanter and the gravity line runs just behind the patella and just in front of the malleoli. The spine has its proper elongated S-shape that provides a spring to cushion the joints and structures of the spine. The line of gravity (plumb line) runs through the body of vertebra L3.

In sway back (forward hip) posture (Figure 12.9), sway refers to the tendency of a person with this posture to sway back and forth (i.e., anteriorly and posteriorly). The reason for this is that with the hips thrust forward, their weight will shift onto the toes and this easily creates a feeling of imbalance so the musculature of the legs and hips will alternate in tension, causing the person to sway back to front as they remain perched on their toes (Kendall et al. 2005). The lumbar spine is extended (hyperlordotic) at the lowest lumbar vertebrae, which are sitting on posteriorly rotated hips. The hip joint is in extension, as are the knees. (The thoracic kyphosis and cervical lordosis are also exaggerated.) The first one or two lumbar vertebrae and lower thoracic vertebrae are often flattened and resist motion. This adds to the compressive force on the lowest hyperextended lumbar.

Muscles creating sway back posture:

- Tight and hypertonic muscles: lumbar erectors, quadratus lumborum; hamstrings and gluteus maximus (for the knees: vastus medialis, vastus lateralis, vastus intermedius).
- Weak and inhibited muscles: abdominals, except for internal oblique which may be hypertonic, iliopsoas, rectus femoris.

The military posture (Figure 12.10) is named for the classic “head up, stomach in, and chest out” position of a soldier at attention. It requires the person to extend their low back (increasing lumbar lordosis) while lengthening or flattening the thoracic kyphosis as the shoulders are retracted. Often the chin is lifted, extending the upper cervical spine. Note that the line of gravity runs slightly behind L3’s vertebral body.

Muscles creating the military posture:

- The low back and mid-back erectors are short and tense, abdominals are tense, rhomboids and lower trapezius are short and tense. The suboccipitals are short and tense, along with the scalenes (holding the first two ribs up).
- The pectoral muscles are also short and tense (lifting the ribs and sternum while lowering the clavicle onto the ribs underneath it).

In the flat back posture (Figure 12.11) the lumbar spine curve is decreased/flattened. As a result, the body compensates for this by throwing the head forward (upper thoracic hyperkyphosis and upper cervical hyperlordosis).

Often, the whole body tilts forward which results in the toes grabbing the ground and the toe flexors, therefore contributing to a pes cavus (high arch) in the foot.

As a result of the at back posture, the pelvis-lumbar complex has:

- Lumbar spine flexed, stretched low back erectors
- Posterior pelvic tilt with extension of hip joint, tight, short hamstrings, short abdominals and lengthened rectus femoris and iliopsoas.

HYPERLORDOTIC POSTURE (LOWER CROSS SYNDROME)

The hyperlordotic posture (Figure 12.12) is associated with a bilateral anterior pelvic tilt, which is a common muscle imbalance found in the clinical setting.

Tight and facilitated muscles:

- Lumbar erectors, QL, iliopsoas, piriformis, rectus femoris, TFL, thigh adductors.
• Taut hamstrings (lengthened but hypertonic): the hamstrings are stretched by being a muscle group holding the pelvis from rotating further anteriorly (along with gluteus medius) and, over time, contracture to this length. Because of this contracturing, they will appear short (loss of extensibility) when tested for length.

Weak and inhibited muscles:
• Rectus abdominis, transversus abdominis, gluteals, vastus medialis and lateralis of the quadriceps.

LUMBAR CURVES AND L3: THE SOURCE OF MANY IMPAIRMENTS AND DYSFUNCTION WITHIN THE LUMBAR SPINE

The lumbar spine’s normal lordosis (anterior curve) is meant to act as a spring to cushion the forces coming from below (as when walking or running) or from above (as in upper body movements and carrying or lifting).

CONTINUED ON PAGE 24
Charting is an everyday aspect of your practice – and a requirement for a regulated health profession. In my reviews of practitioner records, there has been great variability in charting comprehensiveness and style. Assessments and meaningful outcome measures may be absent, and risk of harm is ineffectually screened for. Charting may be perceived as “something I have to do” rather than a real opportunity to effectively capture the person’s health status and symptom picture. The charting process helps uncover otherwise overlooked symptoms that impact quality of life and focus the practitioner’s treatment plan.

Whatever your current charting method, injecting these five principles into your daily records can help you produce meaningful, measurable and more robust records while reducing risk of harm to the people you care for.

Reduce risk of harm
A primary reason for conducting a case history is to reduce risk of harm – to ensure your interventions will not ultimately worsen the person’s condition or health status. The challenge is to keep risk factors top-of-mind as you proceed through care. Building checkpoints into your case history help screen for precautions (“yellow flags”) and preclusions (“red flags”). In *Neuromusculoskeletal Examination and Assessment* by Petty and Moore (Churchill Livingstone), the authors outline a number of conditions that are cause for pause. These include a report of general poor health, fatigue or rapid weight loss, recent diagnostic tests, a history of rheumatoid arthritis, long-term use of medications (particularly steroids and anti-coagulants), neurological symptoms or dizziness. In my case history, I add signs of inflammation or infection, history of trauma, high/low blood pressure, sensory or motor loss, and consideration if the person is elderly, pregnant, or a child.

Once I provided care to a person on a type of blood-thinning medication. Our sessions had yielded positive outcomes generally, but on one occasion I deepened my pressure. This caused the person to suffer with pain and stiffness for several days following. I had lost site of the original yellow flag. Now I incorporate a check-box list of yellow/red flags on my assessment template to ensure I ask specific questions during a case history, and that these concerns garner my attention on each visit.

Draw a professional conclusion
Practitioners go through the trouble of gathering case history information and conducting various assessments, yet may leave their conclusions unformed. A provision in Ontario’s Regulated Health Professions Act lists forming a diagnosis as a protected act, privileged to a small group of gatekeeper health disciplines. RMTs may exclaim, “we can’t diagnose.” It’s true we don’t retain the privilege of conveying a diagnosis, however this doesn’t preclude RMTs from dovetailing case history information with assessment findings to come to a conclusion...a professional opinion. Without a professional opinion, it’s impossible to effectively address all the symptoms and resultant sequelae the person on your table presents with.

State the big picture
The design of your assessment template should allow you to record all pertinent case history information – coupled with additional information gathered, and screening for precautions and preclusions – along with your assessment...
of functional (range of motion, posture, muscle strength and length) and subjective/life quality (pain perception, limits in activities of daily living, effect to sleep, recreation, occupation or social) aspects. You’ll need sufficient room to record your professional opinion, massage applications, post-session outcomes and a treatment plan, along with particulars of date, time/duration, consent provided, practitioner’s signature.

Your assessment template should give a complete picture of the person’s complaints, limitations and health status at this moment in time. This comprehensive picture allows ongoing notes to be concise and targeted, while serving as an official record should your records be audited. It’s also a helpful share document (with the person’s consent) back to their primary health practitioner to update the practitioner on your findings, but also to demonstrate the breadth of your scope.

You may even gain a few referrals from this practice.

**Build a treatment scaffold**

I’ve had the opportunity – both in reviewing charting of RMTs facing disciplinary action, to records submitted in Designated Assessment Centres I’ve been contracted in – to view records in all shapes and sizes. Sometimes I’ve seen only “FBM”, full-body massage. Check-box/multiple choice designs (checking body regions, strokes applied, modalities used) don’t correlate well and fail to properly transcript what actually happened in the session.

While RMTs are not the only profession who suffer from a paucity of detail in our charting, we can improve on how we record the therapy we’ve provided. I recommend building a scaffold - shaping your treatment record by listing body position, methods and modalities applied, body regions treated, and specific areas of concentration. By laying out these variables, you will be able to look back five years on the record and know precisely what treatment you applied and the outcome of that session.

**Measure meaningfully**

It’s important to regularly incorporate recognized functional assessments (range of motion, muscle length/strength) along with exploring quality of life measures like numeric pain scale, impacts to sleep, mood, and recreation/occupation/socialization. Massage therapists benefit from using measures meaningful to them, contribute to better public health, and progress the function and quality of life of their clients/patients.

The RMT profession could benefit from an exploration of terms like myalgia, myositis, myogelosis, and other terms assigning language to what we find under our hands.
We often see clients spend their days sitting behind desks at their nine-to-five office jobs or standing for prolonged periods working in manufacturing or retail.

Commutes may be getting longer due to closed roads, traffic delays or congestion, adding on many more minutes of sedentary time. Then, after their long day, all our clients want to do when they finally arrive home is to sit on the couch to catch up on sports or their guilty pleasure show. That’s not a lot of movement. In fact, according to the Canadian Cancer Society, Canadians sit on average for 69 per cent of the day.

By the time the weekend rolls around, there may be a sudden burst of motivation to get active, attend a spin class or hike that trail. Or maybe the to-do list has grown and precious hours are spent landscaping, snow shovelling, or refinishing that old dresser. All of a sudden, clients are up and moving (albeit only twice per week) and the next day, they’re sore.

THE LIKELY CULPRIT

The symptoms our clients complain about after doing weekend projects is likely delayed onset muscle soreness (DOMS), which is very common – even among high calibre athletes. Minor muscle strain (less than 10 per cent of muscle fibre tearing) would be classified as DOMS. Stretching, joint mobilization, trigger point therapy and even cryotherapy have been shown to reduce discomfort. DOMS will fade away two to three days after activity, so if a therapist is treating them early in the week, it will be a strong indication. However, it’s important to still assess, look for and screen underlying issues that may be contributing factors.

As massage therapists, we need to educate our clients on the importance of regular exercise. When we say “regular exercise,” it can be something as simple as daily walks, plus light resistance exercises a couple of times a week to get the muscles moving and heart pumping. Stretching should also be a part of your client’s home care. Finally, have them be accountable: Write down in your charts what exercises you’ve outlined and how often to do them. At the next appointment, ask if they were compliant.

Encouragement – even if our client did the exercise just once a week – is a massive step forward to getting their regular exercise in, and will still help them condition after the weekend aches and pains decrease.

Massage therapists should also educate clients on movement and regular breaks if they work in an office. Again, it’s simple tasks like getting up to grab some water, going for a bathroom break, or going through a two-minute stretch once an hour is often enough. Asking the client how many hours they work in a day, if they have a commute and what their...
hobbies are, gives us a baseline of how much they sit on a daily basis.

**OBSERVATIONS**
Observing our client in the seated position can show us plenty of repetitive strain issues. Anterior head carriage, medially rotated shoulders and protracted scapulas with associated hyperkyphosis, would be some of the more common observations we would see. When we sit, muscles like the gluteus group and the quadriceps are massive postural muscles that are not being used – our back muscles and abdominals take much of the force and eventually fatigue, compromising our spine.

An individual with strained posture will not have a proper lifting technique, which leads to the use of the back, rather than the legs. A rush to “get the task done” takes over, leading to repetitive strain and twisting, putting even more load on the back. Sitting on our haunches rather than using a healthy squatting position can also put an unnecessary load on the knees. Other weekend tasks may involve awkward body positions, forcing people to torque or twist to reach for, or hold something in place. (Think: reaching for a bolt while working on a car.)

If we ask a client when the discomfort started, and they say it’s gradual, it’s critical to understand what repetitive tasks they are doing. It may be a singular movement that led to the onset of pain, but either way, it’s a good idea to ask your client to show you specifically what they were doing when the pain started. Pain from strain often starts locally and gradually builds into a blanketed area, as the muscles guard other damaged tissue, such as other muscles, sprained ligaments or nerve irritation from a possible disc degeneration, or referral pain creates a larger surface area of discomfort.

Relieving and aggravating factors are a large indicator of what the source of pain is. Does ice or heat help? If they took medication, what kind was it? Was it NSAIDs (more inflammation) or was it analgesic (spasms, guards, strain) and did it help? Does lying down (complete muscle rest), standing (more load on the hip and leg muscles) or sitting (more load on the back and abdominal muscles) relieve the pain?

With range of motion and orthopedic testing, it’s important to communicate with the client that we are trying to recreate patterns of discomfort to help better understand the problem.

Treatment should first focus on immediate symptoms, but there’s always the secondary goal of postural change. Your homecare should be related to posture, even if it means clients have to be more aware of how they sit. Finally, guiding your clients to reputable videos or articles on proper lifting techniques can help keep those “weekend warrior” pains away.

This springiness comes from the shock-absorbing qualities of the intervertebral discs (IVDs). This works well when the spine is generally in a neutral position. In neutral, the plumb line, or line of gravity, runs through the vertebral body of L3, which is also the apex of the normal lumbar lordosis (Bogduk 2012; Mitchell 2001).

However, in most of the postural variations (from neutral), the lumbar curve is held out of line, or repositioned with respect to the line of gravity. This means that the direction of forces on L3 (and the rest of the lumbar spine’s vertebrae and IVDs), are altered. While the lumbar spine is accepting and capable of handling such repositioning for brief moments, the spine is not capable of handling this for long periods of time. Changing the lines of force and tension, etc., inevitably will result in changes to structure and function of the tissues of the spine.

The IVDs, the facet joints, the bony structures and the ligaments are all put under long-term tensile and compressive stresses that will inevitably affect those structures physiologically and structurally. Changes to the orientation (or structure) of the lumbar spine’s curvature will inevitably change how it functions. Changing how the spine functions for extended periods of time will in turn begin to change the very structure of each of the components listed above. Such changes are the primary causes of degenerative disc disease (DDD; disc degeneration, herniation, vertebral body osteophyte formations, etc.) and degenerative joint disease (DJD; e.g., facet joint osteophytes, ligamentous stretching or shortening, synovial joint surface osteoarthritic changes, etc.). Most of these changes, after prolonged postural deviation, are permanent (or only minimally reversible or repairable), even if the normal curve is returned to neutral.

Some examples of lumbar curve impairments and their effects include:

• During hyperlordosis, L3 is shifted in front of the line of gravity. The more L3 moves forward of the gravity line (as in excessive hyperlordosis, e.g., in a sway back), the greater are these excessive forces on the posterior portion of the IVD, resulting in degeneration (cracking and tearing) of the annular fibers. In fact, the nucleus pulposus, which was centered under the lines of force running through L3 (by being slightly posterior within lumbar IVDs), is now being shifted forward of the line of gravity, etc. It now can actually become a fulcrum increasing the amount of compressive forces in the posterior portion of the IVD and the tensile (stretching) forces in the anterior portion of the IVD, much in the same way as shifting more weight to one side of a seesaw (teeter-totter). Osteophytes will begin to form anteriorly in order to try to hold or reinforce the stretching annular fibers, and also posteriorly to reinforce the posterior annular fibers from being crushed and broken down.

• Further, this shift of force or weight may make the facet joints become weight-bearing. This will speed up osteoarthritic changes in these joints. The pars articularis will also receive excessive force and may crack. Ligaments around the facet joint become shortened and so can no longer appropriately guide the movements of the facet joints or properly stabilize the joints at their end-range. This permits excessive side-bending and rotation within the lumbar spine. All of this can also threaten impingement of nerve roots by decreasing the size of the neural foramen.

• A scoliosis (rotoscoliosis) is a lateral curve; a side-bending and rotation in the spine. In the lumbar spine, L3 shifts away from the side to which the spine is bent. As a sustained orientation (posture) of the spine, changes (as in hyperlordosis) to the forces running through the lumbar spine (from above and below) will occur. However, with a scoliosis, the compression happens on the concave side, and the increased tensile forces happen on the convex side. With the addition of rotation (that happens in a scoliosis) the compressive forces are increased within both the disc and the facet joints on the concave side.

• During hypolordosis, L3 may remain somewhat in the line of gravity. However, the flatness of the lumbar spine (from its flexed position, relative to the pelvis) is what changes the lines of force running through the IVD in this case. Now compression occurs in the anterior portion of the disc and tensile in the posterior portion of the disc. The facet joints are gapped excessively, and can no longer momentarily help with weight-bearing during extension of the lumbar spine, nor appropriately guide motions within each spinal motion segment. Stretch (tensile) forces occur to the posterior ligaments and facet joint capsules. Stretch of ligaments around the facet joints will cause these ligaments and joint capsules to undergo excessive tensile force on flexion, rotation, and side-bending: either as individual motions, or especially during a combined motion of all three. Thus making it easier to strain and tear these ligaments, especially if the person is carrying or lifting something.

Due to these changes in the curve of the lumbar spine, we can clearly see how the possibility of injury to the structures of the vertebrae will increase as the deviation of L3 (and all vertebrae) increases from a neutral position. These postural deviations may well play a part in the predisposing factors (or even causes) of most lumbar spine impairments and dysfunctions.
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RMT TECH TALK

Looking ahead
Changes in 2018 that may affect you in 2019

BY JESSICA FOSTER

We have assembled a small collection of the more important recent events of 2018 that may have an impact on your practice in 2019. If your day doesn’t start until you have caught up on recent news that could affect your practice, then let’s get started.

PIPEDA Legislation Addition

New Canadian federal privacy legislation from PIPEDA (The Personal Information Protection and Electronic Documents Act) took effect on November 1st, 2018. The legislation deals with all personal and private information you are responsible to safeguard when you have collected and stored it. Patient information such as that found in appointment records, SOAP Notes, intake forms, billing data and similar, fit into that category. In short, much of the legislation is aimed at preventing data breaches but importantly it now makes it mandatory to report a data breach or potential data breach to your patients and the Office of the Privacy Commissioner of Canada. Failure to report a data breach or potential data breach that poses a risk of significant harm to the individuals, can result in a fine of up to $100,000 per breach. Practitioners need to be aware of this new requirement and have a reporting plan in place should a breach occur.

More information on this legislation is available on the PIPEDA public website.

Canadian Privacy Commission News

Somewhat related to PIPEDA, is the recent news about the former privacy commissioner of Canada’s broad concern about personal health data being transferred from one service provider to another service provider, when one company acquires the other. The two companies in this example, were Google Health and DeepMind. Allegedly, over 1.6 million peoples’ non-de-identified health data transferred from one company to another without the patients’ consent.

In Canada, this type of potential data breach is more decidedly dealt with in provincial healthcare privacy legislations (such as the Personal Health Information Protection Act in Ontario).

Here are some questions you may have about your agreement with your practice management system provider: What is your vendor’s exact policy regarding data held on their systems? Who owns the data? What rights are they claiming for the data’s use? In particular, is that company’s privacy policy compliant with your province’s specific privacy legislation? What if your provider is acquired by another company? If you don’t know the answer to these questions I suggest you stop reading right now and find out! If your vendor’s policy falls anywhere short of “your practice data (including your patient data) is owned by you and/or the tight circle of care providers in your clinic and that it is for your use and no one else’s”, including in the event of an acquisition, you may have already exposed yourself and your patients to a potential data breach.

Website/Search Engine Change

As of July, 2018 Google SSL (Secure Socket Layer) website rankings took effect. If your business has a website that does not incorporate SSL encryption, then this will affect you. SSL is a technology that encrypts the data sent between a browser (i.e. Chrome, Fire Fox, Internet Explorer, etc.) and your website. As of July 2018, Google Chrome and other browsers can display a “not secure” message when visiting a website that does not include an SSL certificate. The words “not secure” in this case is not necessarily referring to the safety of your stored data, it is identifying that the transmission of webpage information across the Internet is not being encrypted. This message obviously is not a great experience for visitors to your website. The message can confuse visitors, harm your credibility and affect your Google search engine ranking. Historically SSL has been a small factor in search engine rankings, its importance has increased to the point it should now not be ignored.

Those who step up their game whenever possible to rank higher with search engines than their competitors, win more business.

To find out if your website incorporates SSL simply go to your website and you will see HTTPS:// as a prefix to your website domain in your browser’s address bar. The “S” in HTTPS indicates that a SSL certificate is installed.

JESSICA FOSTER writes on behalf of mind2play Solutions, provider of massage therapy websites and practice management solutions. To learn more, visit massagemanaged.com.

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