

BULLETIN

June 2010

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Welcome to the June 2010 issue of the NZSOPA Bulletin

As the All Whites prepare to take part in the 2010 FIFA World Cup for the first time in 28 years, this edition of the NZSOPA Bulletin will focus on Soccer.



Soccer Features in the June Bulletin:

Case Report: "Lateral ankle fracture and a missed Maissonneuve injury in a soccer player" M T. Hirschmann, C Mauch, C Mueller, W Mueller, N F. Friederich

Sideline: Article Review—"Efficacy of injury prevention related coach education within netball and soccer" S Gianotti, P Hume, H Tunstall.

Also in this Bulletin:

- NZSOPA Member Survey—WIN AN IPOD pg 2
- Course: "Designing a Spinal Stability Programme" with Trish Wiseby-Roth pg 13.
- Asics Shoe Report: Landreth 6 Running Shoe pg 3
- Auckland Cricket Association—Physiotherapist Position Advertisement pg 14

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We wish the All Whites and support team all the best!!

As always we welcome contributions, case studies, articles or feedback from all members! Send to the Secretary mborich@ihug.co.nz.

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Inside this issue:

Latest News—win an iPod Touch!!	2
Asics Shoe Report—Landreth 6	3
Upcoming Conferences	4
JOSPT—June Edition 2010	5
Member Benefits	6
Case Report: <i>Maisonneuve Injury in a Soccer Player</i>	7
"Sideline" : <i>Efficacy of injury prevention related coach education within netball and soccer</i>	10
NZSOPA Website	12
Educational Courses	13
Classifieds	14

NZSOPA Member Survey—WIN AN APPLE IPOD TOUCH



Complete the survey by June 15th 2010 to be in to win the Apple iPod Touch.

The NZSOPA committee value your opinions with regard to the future direction of our SIG. We therefore invite you to share your ideas with us via an online survey.

This will take approximately 10 minutes and will be extremely valuable to us in planning our direction and improving services for you for the coming years. We will take your opinions on board in our future decisions.

To encourage your responses we are offering an iPod touch 8GB to one lucky respondent provided we receive over 100 replies. **All responses will be anonymous and separate from the prize draw.**

Please click on the below link to access the survey now. <http://www.surveymonkey.com/s/VD62CCG>

COURSE

“Designing a Spinal Stability Programme to Break the Recurrent Pain Cycle”



By Trish Wisbey-Roth

Olympic/Specialist Physiotherapist(FACP)
Masters of Sports Physiotherapy(AIS/UC),
Manipulative Physiotherapist,

Director Bounce Back Active Rehabilitation systems



Where? Auckland (AUT University)

When? Thurs 1st July, 7.30pm

How Much? \$25 at the door

More Info..... See page13 of this Bulletin

ASICS Shoe Report:

Landreth 6 Running Shoe



www.asics.co.nz

Asics originally developed this shoe 5 years ago as a more flexible version of the GT 2100 series shoe. Today the Landreth 6 is clearly placed between the Cumulus and 2100 series shoe.

Targeted toward runner's who have efficient running style but with a form than tends to fatigue with endurance, the shoe focuses less on providing control of medial forces at heel strike but continues to give guidance of peak pronation in the midstance phase.

Key feature of this shoe is its Heel Clutch, a non-plastic heel counter that moulds closer around the heel and allows it to move more freely. There is a notably reduced feeling of stiffness and heaviness at strike phase gait.

There are 7 parts that make up the shoe's outsole. With smaller sized outsole segments the shoe creates less surface tension and it is easier to plantarflex the foot at propulsive phase gait. When the body can reach propulsive gait quickly, this reduces energy expenditure.

Women specific features make it better fitting and more comfortable.

During women's menstrual cycle, peak levels of oestrogen are released on approximately day 15. Oestrogen is a soft tissue relaxant and studies show the Plantar fascia strain reduces and the Plantar fascia drops in height. It is common for women to report arch pain during this time. (Bartold, Nishiwaki 2007) The Landreth 6 has a women specific flexible trusstic (relative to women's body weight) that allows the arch to drop freely at different rates without being irritated by the midshank.

Personal Heel Fit is incorporated into the heel of the shoes' upper. This is a closed cell memory foam that moulds to the wearers' heel and reduces shear forces and blistering.

Biomorphic material with 4-way stretch is added in the 1st and 5th MPJ point where there is high deformation in the upper. Studies show a correlation between low levels of comfort and higher injury rate (Munderman et al 2005) so the above features that are designed to improve comfort levels may contribute to lowering injury.

In a nutshell, the Landreth 6 is a shoe that is designed for

the running style that is generally efficient, but requires midstance guidance for the runner who is under fatigue. The traditional stiff heel counter has been removed as this targeted runner has no need for heavy heel strike control features.

Footnote:

This is currently the ONLY Asics shoe available without hard plastic heel counter. For clients with symptomatic calcaneal ailments such as retrocalcaneal bursitis, insertional Achilles tendinosis or Haglund deformity, this shoe will provide greater comfort than traditional heel counter designs.

I personally feel early midstance pronation is of less importance than late midstance pronation and hence there is less need of stiff and heavy heel counter designs that increase weight and reduce efficiency.

The retailer should analyse this shoe from behind as per normal, but focus on the timing of resupination in the mid foot at heel lift phase, rather than the degree of rear foot pronation at strike phase.

An ideal shoe to compare it to is the 21 series shoe. If mid-foot resupination timing is identical – the Landreth 6 will be preferred option for it's lower weight. If midfoot resupination timing is slower in Landreth 6, the foot requires additional features of the 21 or 31 series shoe.

Monique Ujdur
April 2010



Upcoming Sports Physiotherapy Conferences

NZSOPA Bulletin, June 2010

NZSOPA Calendar

See the NZSOPA website "Calendar" page for more courses and conference information

www.nzsopa.org.nz/calendar.html

1st July 2010

Designing a spinal stability program to break the recurrent pain cycle

Location: AUT University—Auckland

Website: <http://www.nzsopa.org.nz/courses.html>

17-18 September 2010

Sports & Exercise Medicine Annual Conference

Location: RCSI, St Stephen's Green, Dublin 2, Eire

Website: <http://www.rcsi.ie/fsem/asm/index.html>

November 4-6, 2010

Asics Conference of Science & Medicine in Sport

Location: Mirage Resort, Port Douglas, Australia

Website: <http://sma.org.au/asics-conference/>

November 12-14 2010

International Conference on Applied Strength and Conditioning

Location: Gold Coast, Australia

Website: <http://www.strengthandconditioning.org/>

Interested in attending one of these conferences? Apply to the Asics Education Fund for financial assistance. Details page 6.

JOSPT—Free to NZSOPA Members



All NZSOPA Members receive FREE online access to the Journal of Sports & Orthopaedic Physical Therapy (JOSPT) (value USD \$275). This is the official publication of the Sports Physical Therapy Group of the American Physical Therapy Association.

LOGIN: <your email address>

PASSWORD: nzsopa2010

Having Trouble Logging On to JOSPT?

Check the following:

1. Have you paid your membership subscription for the NZSP and NZSOPA for 2010?
2. Check your email address— use the email address that the NZSP have on file for you. Have you changed your email address and not notified PNZ?
3. Password—use small letters for 'nzsopa'

Still having trouble? Contact Michael Borich (secretary) at mborich@ihug.co.nz

June 2010; Volume 40, No.6

IN THIS ISSUE



Time Courses of Adaptation in Lumbar Extensor Performance of Patients With a Single-Level Microdiscectomy During a Physical Therapy Exercise Program

Sean P. Flanagan, Kennelie Kulig, PT ClinReaNet

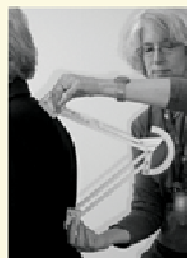


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CLINICAL COMMENTARY

Age-Related Hyperkyphosis: Its Causes, Consequences, and Management

Wendy B. Katzman, Linda Wanek, John A. Shepherd, Deborah E. Sellmeyer



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CASE REPORT

Differential Diagnosis and Physical Therapy Management of a Patient With Radial Wrist Pain of 6 Months' Duration: A Case Report

Javier González-Iglesias, Peter Huijbregts, César Fernández-de-los-Peñas, Joshua A. Cleland



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ALSO IN THIS ISSUE

EDITORIAL

The Mobile Edition: JOSPT to Go!

Guy G. Simoneau

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RESEARCH REPORT

Factors Associated With Calf Muscle Endurance Recovery 1 Year After Achilles Tendon Rupture Repair

Geoff P. Bostick, Nadr M. Jomha, Amar A. Suchak, Lauren A. Beaupré

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RESEARCH REPORT

Trunk Muscle Activity During Lumbar Stabilization Exercises on Both a Stable and Unstable Surface

Atsushi Imai, Koji Kaneoka, Yu Okubo, Itsuo Shima, Masaki Tatsumura, Shigeki Izumi, Hitoshi Shiraki

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MUSCULOSKELETAL IMAGING

Sign of the Buttock Following Total Hip Arthroplasty

Scott A. Burns, Mark Burshteyn, Paul E. Mintken

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PRACTICE GUIDELINES

Knee Pain and Mobility Impairments: Meniscal and Articular Cartilage Lesions

David S. Logerstedt, Lynn Snyder-Mackler, Richard C. Ritter, Michael J. Axe

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NEW PRODUCTS

June 2010 New Products

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NZSOPA Membership currently stands at \$45. The NZSOPA Executive are continually striving to maximize value for the membership dollar.

Members currently receive a number of other substantial benefits for the \$45 membership, including:

- ASICS shoes and apparel at wholesale prices!!
- EXCLUSIVE access to the proposed Sports Physiotherapy Australia Level 1-2 courses
- FREE online access to JOSPT (value USD\$275)
- FREE Edition of the Quarterly APA "Sports Physio" Magazine
- 20% Discount on McGraw-Hill Publications
- Funding Support for Conferences/Courses/Research (by application)
- Substantial discount, Advanced Notice and preferential placing on Educational Courses.
- Access to website with clinical and relevant articles.
- Bi-monthly NZSOPA Bulletin featuring Activity, Course and information updates.
- FREE classified advertising in the NZSOPA Bulletin

NZSOPA 4th Year Physiotherapy Student Research Award

NZSOPA sponsor a \$500 award for the best 4th Year Student research project relevant to Sports & Orthopaedic Physiotherapy, from each physiotherapy school.



Asics Education Fund

The NZSOPA Education Fund was established in 2007, with the aim of assisting its' members to conduct research, or attend a conference related to Sports & Orthopaedic Physiotherapy.

Any member may apply. Simply complete the application form found at:

<http://www.nzsopa.org.nz/education.html>

and send in with your CV to the NZSOPA Secretary by the due dates:

We are proud to announce Asics sponsorship for the Education Fund from 2010.

31st March 2010 and 31st August 2010

Next application due date for the ASICS Education Fund is 31st August 2010. Get your application form in for the chance of receiving \$1000 in financial support.

A Case Report of a missed Maisonneuve injury in a soccer player -a timely reminder to check the joints ABOVE and BELOW the injured part!

Lateral ankle fracture with missed proximal tibiofibular joint instability (Maisonneuve injury).

M T. Hirschmann, C Mauch, C Mueller, W Mueller, N F. Friederich

Knee Surg Sports Traumatol Arthrosc (2008) 16, p952–956

ABSTRACT

We present a case of a soccer player who sustained a lateral ankle fracture and the associated proximal anterolateral tibiofibular joint instability (Maisonneuve injury) was overlooked. After a non-contact injury the (incomplete) diagnosis of a lateral malleolar fracture (type Weber B, AO 44-B1) was made and the patient was surgically treated with open reduction and internal fixation including a distal syndesmosis screw. After removal of the syndesmosis screw (six weeks after surgery) the patient suffered from activity-related pain around the fibular head. After thorough clinical and radiologic examination, temporary screw transfixation of the fibular head and capsular repair under meticulous fluoroscopic control of fibular rotation helped to restore patient's sport activity level. This case report emphasizes the importance of precise clinical examination for detection of a proximal tibiofibular joint instability. Restoration of a well functioning and stable proximal tibiofibular joint may be difficult to achieve in previously operated and missed instabilities.

Case history

A 39-year-old male social soccer player had sustained a non-contact injury with violent external rotation of the left ankle 6 months before presentation to us. At this time the (incomplete) diagnosis of a distal lateral malleolar fracture (see Fig. 1) was made and the patient was surgically treated with open reduction and internal fixation of the ankle fracture.

At surgery it was noted that he had a distal syndesmotom instability requiring insertion of a distal syndesmosis screw (Fig. 2a). Up to this

point no clinical examination or radiographs of the proximal fibula and the proximal tibiofibular joint were performed.

Six months after surgery, and after screw removal which had taken place 6 weeks post surgery, the patient complained about



Fig. 1 Radiographs directly after soccer injury showing a slightly displaced lateral malleolar fracture (a) Lateral view (b) Anteroposterior view

increasing activity related pain at the proximal tibiofibular joint. He was sent to our department by his physiotherapist for further evaluation. When we first saw the patient he presented with local tenderness and a pathologically increased joint play at the proximal tibiofibular joint. When contracting the biceps femoris muscle the patient was able to willingly dislocate and reduce the fibula in a

Fig. 2 Weightbearing radiographs of left ankle and left knee. a Anteroposterior and lateral view of left ankle after open reduction and internal fixation of the ankle fracture. b Anteroposterior and lateral view of left knee after initial presentation to our department



posterior direction. With the knee in 90deg flexion and maximal passive external rotation, the proximal fibula dislocated with a clicking sound. After sport activity the patient regularly noted a transient loss of sensation and a tingling feeling in the region of the fibular head.

To confirm our suspicion of a proximal tibiofibular joint instability, anteroposterior and lateral weightbearing radiographs were conducted, which showed a horizontal type of proximal tibiofibular articulation. It did not reveal any clear abnormality (Fig. 2b). In anteroposterior and lateral stress fluoroscopies an anteroposterior instability was subtly demonstrated. An MRI eight months after trauma demonstrated a joint effusion with irregular soft tissue structures following a previous tear of the anterior tibiofibular ligament (Fig. 3). A multi slice CT scan showed subluxation of the fibular head with full external rotation of the lower leg when compared to the contralateral side (Fig. 4). It was decided to treat him surgically.

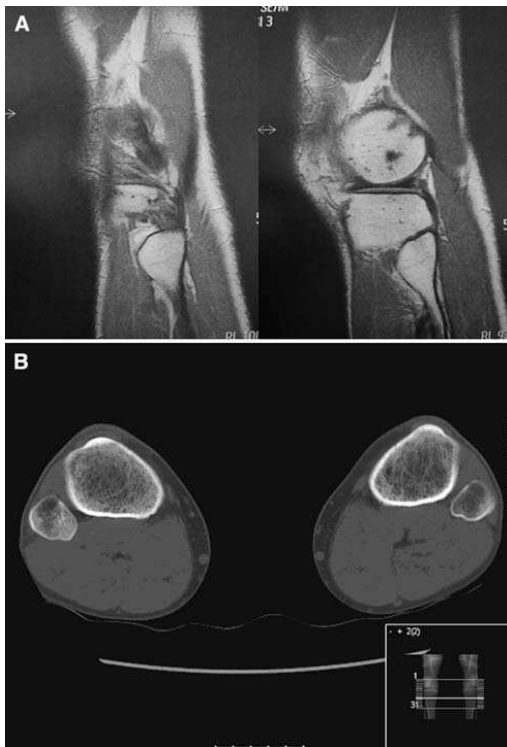


Fig. 3 MRI and CT scan of left knee 8 months after injury **A** MRI indicating a subtle irregularity of the anterior proximal tibiofibular joint and minor effusion. **B** CT scan of left knee demonstrating a minimal anteriorly displaced fibula head

Under anaesthesia the dislocation was reproduced in full external rotation of the lower leg with flexed knee (90deg). Manually the fibular head could be easily dislocated and reduced. Intraoperatively we found that the proximal anterior tibiofibular ligament was torn.

After debridement of the joint space the proximal tibiofibular joint was correctly reduced and stabilized with a 4.5 mm cannulated proximal lag screw. In addition, a capsular suture repair was performed including

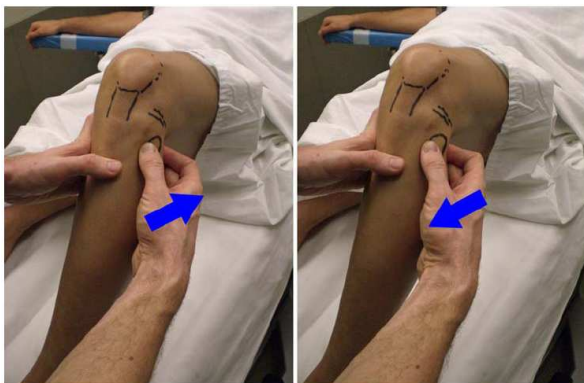


Fig 4. Clinical examination under anaesthesia with grossly-antero-posterior translation and rotational instability of the fibular head 8 months after injury

the overlapping biceps tendon strings. The lateral collateral ligament and the posterolateral corner was uninjured and stable.

Immediately after surgery partial weightbearing with half body weight was allowed for 12 weeks and early functional physical therapy was initiated. The patient was followed up with antero-posterior full weightbearing radiographs and clinical assessment at 6 and 12 weeks and 6 and 12 months after surgery. A planned screw removal was performed 12 weeks postoperatively. At the last evaluation 6 months after surgery the activity related level of pain was rated as none. No medication for relief of pain was required. The patient was completely satisfied and returned to social soccer.

Discussion

There are several publications, mostly small numbered case series and some review articles, which deal with the diagnostic and therapeutic challenge of proximal tibiofibular joint instabilities. This case report is unique because it describes a missed proximal tibiofibular anterolateral instability in a soccer player, who had sustained a distal lateral malleolar fracture. Thus the diagnosis (lateral ankle fracture) was incomplete missing the rare, but in this case disabling concomitant disruption of the proximal anterior tibiofibular ligament.

Importance of Diagnosis

As a dislocation of the proximal fibula is a rare entity the importance of precise history making and careful standardized examination with a high level of clinical suspicion cannot be overestimated. Clearly, the whole tibiofibular system from the upper talar joint to the knee joint should be meticulously evaluated. Additionally, individually adjusted maneuvers that provoke subluxation dislocation of the fibula out of the groove are imperative.

Interpretation of Investigations

It is even more important as static radiologic examinations i.e. plain radiographs, CT scan or MRI often present with none or only subtle changes, that may be overlooked. Radiographs, whether weight bearing or not, may misleadingly appear to indicate no finding although a pathology is present. If every clinical as well as radiological procedure fails to demonstrate the pathology and there still is a high suspicion for an instability of the proximal tibiofibular joint, then an examination under anaesthesia is recommended.

NZSOPA Bulletin, June 2010

Management

The optimal treatment strategy of a proximal tibiofibular joint instability is still under debate. Conservative treatment with closed reduction may be only possible in few cases of acutely diagnosed instabilities. Delayed diagnosis or missed instabilities should be treated operatively as closed reduction generally is not feasible.

Choice of Surgical Procedure

A variety of operative treatment options such as several types of temporary fixation with screws or K-wire, permanent arthrodesis of the proximal tibiofibular joint in combination with a fibular osteotomy or fibular head resection, have been described with inhomogenous functional and subjective results.

In addition, reconstructive procedures with biceps femoris tendon or iliotibial tract were reported. A resection of the head of the fibula or a permanent arthrodesis of the joint are not advisable as these lead to unpredictable less satisfying results, especially in patients with further sport demands. This may be due to the fact that resection of the head of the fibula goes along with extensive soft tissue dissection and destruction of the insertion of the biceps femoris muscle, popliteofibular ligament and lateral collateral ligament. This relevant change of anatomy possibly leads to consequent lateral laxity and the peroneal nerve may be injured.

Long-term Complications of Arthrodesis

A major drawback of permanent arthrodesis of the proximal tibiofibular joint with or without fibular osteotomy are persistent lateral knee pain, loss of motion and progression of osteoarthritis of the ankle joint. Main principle of operative treatment should always be not to transfer a problem of one joint to another, but to solve the problem at site of origin. In our opinion the restoration of a well functioning and stable proximal tibiofibular joint should be performed with as less as possible inherent collateral tissue damage.

We believe that if technically feasible an open reduction with capsular repair and subsequent temporary screw transfixation serves best to achieve this aim. The use of biceps femoris tendon or iliotibial tract theoretically leads to disturbance of the lateral stabilizers. However, due to the rarity of this injury there is no and probably will never be any prospective randomized data comparing results of temporary transfixation with biceps tendon or iliotibial tract reconstruction.

In this exceptional case, the used operative method showed a good functional result with a satisfied painfree patient at the last follow up control.



CLINICAL PRACTICE POINTS— Maisonneuve Injury

The Maisonneuve injury, named after Jules Germain Francois Maisonneuve, is a spiral fracture of the upper third of the fibula with disruption of the distal tibiofibular syndesmosis and associated injuries (eg, fracture of the medial malleolus, fracture of the posterior malleolus, and rupture of the deltoid ligament).

The Maisonneuve fracture is reported to be a special type of pronation-eversion fracture. These authors classified this fracture into 4 stages: (1) injury of the medial structures, including medial malleolar fracture or rupture of the deltoid ligament; (2) rupture of the tibiofibular ligament or avulsion fracture of one of its bony insertions, or with intraosseous ligament rupture and partial rupture of IOM in the distal third of the leg; (3) fracture of the proximal portion of the fibula; and (4) avulsion fracture of the posterior tibial tubercle.

Due to the predominance of symptoms around the ankle and distal tibio-fibular joint, injuries to more proximal structures such as the Maisonneuve Injury are often missed. Key clinical points:

- Always assess the proximal fibula/knee region when assessing ankle injuries
- If proximal fibula or proximal tibio-fibular joint injury is suspected always ensure this region is included on plain film X-Ray.

More information: <http://www.orthosupersite.com/view.aspx?rid=61231>

Each edition of the NZSOPA Bulletin will contain an article relevant to the assessment or management of sports injuries. Contributions to "Sideline" from members are most welcome!

Efficacy of injury prevention related coach education within netball and soccer

Simon Gianotti, Patria A. Hume, Helen Tunstall

Journal of Science and Medicine in Sport 13 (2010) p32–35

ABSTRACT

In 2004, Netball New Zealand and New Zealand Football adapted a generic 10-point action plan for sports injury prevention, SportSmart, to create NetballSmart and SoccerSmart, as part of their coach education programmes. A small-size descriptive study was conducted in both sports, to assess the efficacy of integrating sports injury prevention into coach education. NetballSmart was evaluated at the end of 2005, via a telephone survey of 217 coaches (53% response rate) who had attended a NetballSmart course earlier in the year. SoccerSmart was evaluated at the start of 2007, via an Internet questionnaire completed by 71 coaches (20% response rate) who had attended a SoccerSmart course in 2006. The evaluations focused on the quality and use of the course resource material, as well as assessing the extent to which coaches had incorporated injury prevention behaviours into player practices. After attending a NetballSmart course, 89% of coaches changed the way they coached, with 95% reported using knowledge from the course and passing it on to players. Ninety-six percent of football/soccer coaches also changed the way they coached, with most change relating to warm-up/cool-down and stretch (65%), technique (63%), fitness (60%) and nutrition/hydration (58%) practices. Although this was a descriptive study in nature, with a small sample size, we conclude that integration of injury prevention content within coach education courses and resources may be a viable and effective strategy to help community coaches – and therefore community players – help reduce their risk of injury.

INTRODUCTION

Anyone who has worked as a physiotherapist in the sporting environment will know that implementation of 'best-practice' injury prevention, training and recovery occurs most effectively when there is a united and consistent approach from all members of the coaching and support team (physiotherapy, strength & conditioning, nutrition etc). In most cases, athletes interact with coaching staff more than any other member of the support team. However the effectiveness of coach education on injury prevention practice and outcome has received little research attention.

The research described in this article was undertaken in association with the ACC following the success of the successful development of the 10-point action plan for sports injury prevention (*SportSmart*) and later a rugby-specific version called *RugbySmart*, NetballSmart (www.netballsmart.co.nz) and SoccerSmart (www.soccersmart.co.nz) were developed

to complement other sport-specific coach education courses and resources. The main aim of this study was to determine if coaches found the information provided by coach education of sufficient use and relevance to subsequently incorporate it into their coaching.

COMPONENTS OF THE PROGRAMME

All main injury prevention components were included: (1) screening; (2) warm-up, cool-down and stretch; (3) physical conditioning; (4) technique; (5) fair play; (6) protective equipment; (7) hydration and nutrition; (8) injury reporting; (9) environment; and (10) injury management (see www.acc.co.nz/sportsmart for more details).

COACH EDUCATION

As part of the *SoccerSmart* programme, NZ Football created a booklet and wallet card that addressed all 10 of the *SoccerSmart* action points listed above. In addition,

a DVD and poster of “*The 11*” training programme produced by football’s international governing body, Fédération Internationale de Football Association (FIFA), and adapted versions of the *Sideline Concussion Card* and associated poster were also included in the *SoccerSmart* course pack.

Football/Soccer coaches received *SoccerSmart* education over a 12-month period, after which they were surveyed to determine if they went on to implement in the subsequent season; what they found useful; how the course information had changed their behavior and whether or not they were using “*The 11*”.

The Netball coaches received similar types of education—details provided in the article.

RESULTS

Response rate from those attending the soccer education sessions was only 20% (netball 53%). Soccer coaches considered the booklet the most useful resource, followed by the DVD, concussion card and wallet card. The specific aspects of coaching behavior that changed are summarized in the table below—taken from the article.

Most notable behavior change occurred in “player profiling”, “environmental factors”, “fitness”, “nutrition/hydration” and “injury surveillance”. Least behavior change was noted for “protective equipment” and “fair play” with many coaches reporting they were already doing this. Most self-reported improvement occurred in the areas of Warm-up/Cool-down”; “Technique”; “Fitness and “Nutrition/ Hydration” practices.

DISCUSSION

Results demonstrated good uptake of information where there was infrastructure support for education systems. Coaching practices changed as a result of the education, and there was long-term retention and effect on coaching practice (up to 1 further season).

Football/soccer coaches gained the greatest benefit from the action points relating to core aspects of their sport, e.g., warming up, technique and conditioning. This suggests these areas would be a good starting point for the implementation of coach education to facilitate the adoption of other action points.

The authors raised a valid point relating to funding of new education models within sporting organisations. There needs to be a clear implementation plan, including funding mechanisms, if the models developed are to be incorporated by community sport. Partnership with the respective National Sporting Organisations is also key to successful implementation at community level.

PRACTICAL IMPLICATIONS

- The integration of injury prevention messages into coach education courses and resources appears to be a viable mechanism for the implementation and delivery of injury prevention strategies in community sport.
- Organisations considering promoting injury prevention should investigate community coach education as an option to reach large numbers of community level players.



www.soccersmart.co.nz

Self-reported behaviour of coaches (n= 62) post-course in relation each SoccerSmart component, as a % of all coaches.

	I am now including this	I was already doing this but I have made improvements	I was already doing this	I still do not do this
Player profiling	16 (26%)	14 (23%)	9 (15%)	23 (37%)
Warm-up and cool-down	7 (11%)	33 (53%)	20 (32%)	2 (3%)
Fitness	11 (18%)	26 (42%)	20 (32%)	5 (8%)
Technique	7 (11%)	32 (52%)	22 (35%)	1 (2%)
Fair play	2 (3%)	11 (18%)	47 (76%)	2 (3%)
Protective equipment	3 (5%)	13 (21%)	42 (68%)	4 (6%)
Nutrition/hydration	11 (18%)	25 (40%)	18 (29%)	8 (13%)
Injury surveillance	10 (16%)	19 (31%)	17 (27%)	16 (26%)
Environmental factors	11 (18%)	13 (21%)	18 (29%)	20 (32%)
Injury management	7 (11%)	19 (31%)	22 (35%)	14 (23%)

NZSOPA Website Information

NZSOPA Bulletin, June 2010

www.nzsopa.org.nz

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Keep updated with the latest information sent straight to your computer.

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Login to the website using your email address and password to access Members Only Section.

Login: <your email address>

Password: <individual password sent to you by NZSOPA>

For help contact the web manager at help@nzsopa.org.nz

Members Only

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Designing a spinal stability program to break the recurrent pain cycle.

By Trish Wisbey-Roth



Olympic/Specialist Physiotherapist(FACP)
Masters of Sports Physiotherapy(AIS/UC),
Manipulative Physiotherapist,
Director Bounce Back Active Rehabilitation systems

Dynamic motor control of the lumbo/pelvic/hip region involves complex movement patterns and interrelated Kinematics of many joints. Not only must key muscles have endurance and contraction specific strength, but the Central nervous system must consider input from the periphery and adjust its pre-programmed responses accordingly.

An explosion of research into muscle and proprioceptive requirements in the region and changes that occur with pain, give us insight into the many aspects of rehabilitation that must be considered to maximise dynamic function. Such changes include: - local muscle changes, function specific recruitment patterns, degradation of proprioceptive, balance and motor planning systems, all combined with faulty virtual body engrams within the motor cortex itself.


The aim of this workshop is to present an exercise based strategy to break the recurrent pain cycle. This strategy involves specific, graded and functional exercises to optimise not only stabiliser muscle endurance but optimise dynamic function. The graded and progressed exercise principles can be used both within the clinic and incorporated into rehabilitation and maintenance training programs for athletes.

If motor control retraining is too unidimensional and does not address retraining the complex proprioceptive and motor planning components of dynamics movement, than dysfunctional movement patterns can continue well after initial pain has settled predisposing the individual to recurrent pain and suboptimal performance.



'DESIGNING A CORE STABILITY PROGRAM'

designed & delivered by
Trish Wisbey-Roth
Masters of Sport Physiotherapy (AJS/UC)
Australian Olympic Specialist Physiotherapist (FACP)
Orthopedic Manipulative Physiotherapist



PRACTICAL • FUNCTIONAL • DYNAMIC

"A Leading Expert in Spinal Rehabilitation"

- the latest research findings
- motor control and kinematics of the lumbo/pelvic/hip region
 - optimising specific, graded and functional exercises
 - maximise dynamic function
- graded and progressive exercise principles
 - easy to follow, ready to use knowledge

Registration & Enquiries: sheldon@thebodyworkshop.co.nz
Cost: \$25 on the door. Cash only. Receipt on payment.
Venue: AUT, Akoranga Drive. Room to be confirmed. **Date:** Thurs 1st July 7.30 start

Kennedy Road Physiotherapy Clinic, NAPIER

An opportunity exists for a motivated, enthusiastic and dynamic physiotherapist to join our friendly team. The right applicant will have Manual Therapy skills and more than 5 years experience, a positive attitude and good communication skills. Post-graduate qualifications are an advantage. Clinic accredited and owner is a key provider to the New Zealand Academy of Sport and an Endorsed College Member.

We are able to offer:

- A fantastic location in ever popular Hawkes Bay
- Excellent remuneration

Opportunities are available to work with sports teams. Our Physiotherapists have a close working relationship with local GPs, specialists and play an active role in the Hawkes Bay community.

Expressions of interest, close 14th June,

Please contact Garry Sye email syenapier@clear.net.nz

All enquiries strictly confidential.



Auckland Cricket Association Physiotherapist Services 2010/2011

**Auckland Cricket Association seek the services of a physiotherapist for the 2010/2011 season.
A job description and details of service requirements are attached.**

Interested parties are asked to apply for this employment or contract position by sending through to Auckland Cricket's High Performance Manager a CV, covering letter and proposal on how they would meet the requirements as per the attachments no later than **Wednesday 9th June** by E-mail: kpatel@aucklandcricket.co.nz; or mail: Auckland Cricket Association, Attn High Performance Manager, Private bag 56 906, Dominion Road, Auckland.

If you have any specific enquiries regarding this position please contact:

Kaushik Patel, 021 713066, 09 815 4856 or kpatel@aucklandcricket.co.nz;

Closing Date: Wednesday 9th June 2010