

BULLETIN

October 2010

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click paperclip
(bottom left of screen)



Congratulations to the NZ Commonwealth Games Medalists



Congratulations to all the NZ Commonwealth Games medalists. Congratulations also to all the medical and physiotherapy support staff who work tirelessly and often without recognition to help these athletes perform at their best.

GOLD (6)

Valerie Adams - (athletics) shot put
 Alison Shanks - (cycling) women's 3000m individual pursuit
 Jaclyn Hawkes & Joelle King - (squash) women's doubles
 Mike Collings & John Snowden - (shooting) mens 1000 yards pairs fullbore open
 NZ Sevens Team
 Silver Ferns - women's netball

Bronze (8)

Athletics:
 Nick Willis - men's 1500m
 Andrea Miller - women's 100m hurdles

Cycling:
 Sam Webster - men's sprint
 Simon van Velthoven - men's keirin
 Eddie Dawkins - men's 1km time trial

Swimming:
 Hayley Palmer - 50m freestyle
 Hayley Palmer, Penny Marshall, Amaka Gessler & Natasha Hind - 4x200m women's relay team
 Men's Black Sticks Hockey

Medals by Sport:

Cycling: 11	Shooting: 2	Rugby: 1
Athletics: 8	Squash: 2	Netball: 1
Swimming: 6	Hockey: 2	
Weightlifting: 2	Bowls: 1	

Silver (22)

Athletics:
 Stuart Farquhar - men's javelin
 Nikki Hamblin (x2) - women's 800m & 1500m
 Brent Newdick - men's decathlon
 Jess Hamill—women's parasport shot put

Cycling:
 Hayden Roulston - men's road race
 Linda Villumsen - women's individual time trial
 Joanne Kiesanowski - women's scratch race
 Jesse Sergent, Sam Bewley, Marc Ryan & Westley Gough - men's team pursuit
 Ethan Mitchell, Sam Webster & Eddie Dawkins - men's sprint
 Jesse Sergent - men's 4000m individual pursuit
 Lauren Ellis - women's points race

Swimming:
 Lauren Boyle, Penny Marshall, Amaka Gessler & Natasha Hind - women's 4x200m Freestyle Team
 Gareth Kean - 200m backstroke
 Daniel Bell - 100m backstroke
 Glenn Snyders - 50m breaststroke

Weightlifting:
 Stanislav Chalaev - men's 105kg weightlifting
 Richard Patterson - men's 85kg weightlifting

Val Smith - (bowls) women's lawn bowls
 Greg Yelavich & Allan Earle - (shooting) centrefire pistol teams
 Joelle King & Martin Knight - (squash) mixed doubles squash
 Women's Black Sticks Hockey



Valerie Adams.

Alison Shanks.

NZ Sevens Team.

Jaclyn Hawkes & Joelle King.

John Snowden.

Silver Ferns Netball.


NZSOPA Annual General Meeting 2010

The NZSOPA AGM will be held at the same time as the 2010 Sports Medicine & Science Conference:

Date: Saturday 20th November 2010

Venue: Duxton Hotel
170 Wakefield St
Wellington, NZ

Time: 4.00pm

The AGM notice, agenda, nomination forms, notices of motion and proposed new SIG rules are included in the attachments to this Bulletin. Click on the paperclip at the bottom left of your pdf screen to open the attachment. 


Any nominations or notices of motion are to be received by the Secretary, 26 Vine St, St Marys Bay, Auckland before 5pm on Friday 19th November 2010.

Survey Results—NZSOPA Name

Thanks to all members who provided feedback in our recent survey.

As part of the Physiotherapy New Zealand re-branding process the NZSOPA Executive are considering whether a name change is required. The results of our recent membership survey on this issue are presented below. Results show the majority of members preferred “Sports Physiotherapy New Zealand” should the name of the group be changed.

We had a number of comments expressing concern that ‘orthopaedics’ may be dropped from the group name. We would like to assure all members that any name change would not alter the intention of the group to cover orthopaedic or associated rehabilitation content.

	Most Liked		Least Liked	Rating Average	Response Count
NZSOPA (New Zealand Sports and Orthopaedic Physiotherapy Association)	20.3% (48)	66.9% (158)	12.7% (30)	1.92	236
Sports Physiotherapy New Zealand (SPNZ)	81.3% (217)	16.1% (43)	2.6% (7)	1.21	267
Physiotherapy New Zealand - Sports	3.9% (10)	11.4% (29)	84.6% (215)	2.81	254
 Show replies Comments please					55
answered question					275

NZSOPA Editorial Assistants

Thanks to all those who expressed interest in the position of Editorial Assistant which was advertised in our last Bulletin. Due to the large number of responses, we extended this to two positions.

Thanks to David Rice and Nicola Thompson for accepting these positions and for their contributions to this (and future) Bulletins.

From the other responses received we have also established a wider group of members who are willing to help out with miscellaneous group activities on an 'as needed' basis. If anyone else is interested in being involved please let us know. We are very keen to have input from members and for any assistance no matter how small.

Online Clinical Forum

www.nzsopa.org.nz/forum.html

GOT A BURNING CLINICAL QUESTION?

NEED ADVICE FROM SOMEONE WORKING IN A PARTICULAR SPORT OR AREA OF PRACTICE?

The NZSOPA online clinical forum is now up and running!

In the 2010 NZSOPA Membership Survey a number of members suggested a forum where they could ask clinical questions anonymously and get suggestions and advice from other members of the group who may have areas of specialist expertise within sports and orthopaedic physiotherapy practice. We thought this was a great idea for sharing clinical knowledge.

In response to those requests, Hamish has developed an ONLINE CLINICAL FORUM where:

- All members can ASK questions (anonymously) AND
- All members can ANSWER questions (please use your name on replies)

To make it anonymous there is a universal login which can be found on the Clinical Forum page. (You can provide your name if you want to). [Click here](#) to go to the login page. Universal login details are:

Login: member@nzsopa.org.nz

Password: [member](#)

So go ahead, it's up and running. And remember:

THERE'S NO SUCH THING AS A SILLY QUESTION.

Members are willing to help.

The “Bench-Presser's Shoulder”: an overuse insertional tendinopathy of the pectoralis minor muscle

Deepak N Bhatia, Joe F de Beer, Karin S van Rooyen, Francis Lam and Donald F du Toit

British Journal of Sports Medicine (2007) August 41(8): e1-e4

Abstract

Tendinopathies of the rotator cuff muscles, biceps tendon and pectoralis major muscle are common causes of shoulder pain in athletes. Overuse insertional tendinopathy of pectoralis minor is a previously undescribed cause of shoulder pain in weightlifters/sportsmen.

Objectives: To describe the clinical features, diagnostic tests and results of an overuse insertional tendinopathy of the pectoralis minor muscle.

Methods: Between 2005 and 2006, seven sports people presenting with this condition were diagnosed and treated at the Cape Shoulder Institute, Cape Town, South Africa.

Results: In five subjects, the initiating and aggravating factor was performance of the bench-press exercise (hence the term “bench-presser's shoulder”). Medial juxta-coracoid tenderness, a painful active-contraction test and bench-press manoeuvre, and decrease in pain after ultrasound-guided injection of a local anaesthetic agent into the enthesis, in the absence of any other clinically/radiologically apparent pathology, were diagnostic of pectoralis minor insertional tendinopathy. All seven subjects were successfully treated with a single ultrasound-guided injection of a corticosteroid into the enthesis of pectoralis minor followed by a period of rest and stretching exercises.

Conclusions: This study describes the clinical features and management of pectoralis minor insertional tendinopathy, secondary to the bench-press type of weightlifting.

Introduction

Tendinopathies are commonly reported injuries in both professional and recreational athletes. Enthesiopathy, or insertional tendinopathy, is one of the most common forms of tendinopathy.¹ Tendinopathy of the rotator cuff, long head of biceps and pectoralis major muscle are all commonly implicated in the aetiology of shoulder pain in athletes.^{2,3,4} This paper presents an overuse insertional tendinopathy of the pectoralis minor muscle, which has not been previously described in the literature. Lying deep to the pectoralis major, pectoralis minor is a thin triangular muscle originating from the 3rd, 4th and 5th ribs. Its fibers ascend laterally and converge in a flat tendon which attaches to the upper surface and medial border of the coracoid process of the scapula. The function of the pectoralis minor is to tilt the scapula anteriorly allowing the coracoid process to move anteriorly and caudally.⁵ Sports and training activities such as swimming, bench-pressing and push up exercises that involve this anterior translation of the scapula can theoretically result in overuse of this muscle, especially in the presence of poor technique or a rapid increase in training load, frequency or duration.¹

Materials and Methods

Between 2005 and 2006, seven subjects (five male, two female) were diagnosed and successfully treated for overuse tendinopathies of the pectoralis minor muscle. Mean age of the subjects was 32 years (range 17–62 years). Three subjects

were competitive athletes, while four were recreational. The dominant upper extremity was involved in three subjects and non-dominant in four subjects. Onset of symptoms were sub-acute in five subjects, mean (range) duration 4.5 (1.5–12) weeks, with pain first occurring after a recent increase in the bench-press exercise. Onset was gradual in the other two subjects (7–9 months).

All subjects were evaluated by clinical, radiographic and ultrasonographic examinations. Clinical evaluation included a subjective evaluation of pain and functional status, and assessment to clear the shoulder of other pathology using standard clinical tests for glenohumeral stability, acromioclavicular joint, biceps tendon and rotator cuff integrity.^{6,7,8} In addition, each shoulder was scored using the Constant and Murley⁹ method of functional assessment of the shoulder. Radiographic evaluation excluded stress fractures or any other bony pathology. Ultrasonographic evaluation was used to assess the integrity of the rotator cuff, biceps tendon and pectoralis minor muscle, excluding an isolated tear of the latter.

The pectoralis minor muscle was then tested clinically by palpating for tenderness along the inferior-medial orientation of the muscle fibres medial to the coracoids process. Active contraction of the muscle was tested as described in literature by Kendall and McCreary⁵ with the subject thrusting shoulder forward against examiner's downward pressure (Figure 2A). A provocative test (bench-press manoeuvre) was devised to assess the nature of symptoms experienced by the subjects while

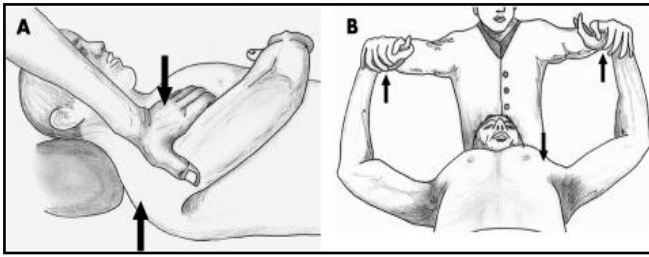


Figure 2 (A) Active contraction test for the pectoralis minor muscle. The subject actively thrusts the shoulder forward against the examiner's resistance. (B) Bench-press manoeuvre for provocative testing of pectoralis minor insertional tendinopathy. Subject exerts an upward force against resistance, reproducing a bench-press exercise. Pain medial to the coracoid (lower arrow) indicates a positive test.

performing bench-press exercise. (Figure 2B.). Finally, a therapeutic test, consisting of ultrasound-guided injection of a local anaesthetic agent and a corticosteroid, was performed into the insertion of pectoralis minor tendon, to confirm and treat the tendinopathy.

All seven subjects were followed up at 2, 4 and 6 weeks after their assessment. During this period, all sporting activities involving the upper limb were discontinued and a stretching regime of the pectoralis minor was prescribed.¹⁰ Sporting activities were then gradually resumed. A final functional assessment (clinical and ultrasonographic evaluations, Constant shoulder score) was performed at 12 weeks after the initial assessment.

Statistical analysis of the data was performed to determine the significance between the preoperative and postoperative Constant scores.

Results

All seven subjects described pain to be moderate to severe in intensity, limiting their sporting and daily activities. In five subjects the initiating and aggravating factor was the bench-press exercise. The glenohumeral joint was stable and tests for rotator cuff, biceps tendon and acromioclavicular joint pathologies were negative in all seven subjects. The mean (range) Constant and Murley score at initial assessment was 76% (71–79%). Radiographic and ultrasound examinations were normal in all seven subjects.

Medial coracoid tenderness or pain on performance of active contraction test and/or the bench-press manoeuvre, and reduction of this tenderness or pain after injection of a local anaesthetic agent, were interpreted as positive tests for pectoralis minor insertional tendinopathy. Pinpoint medial tenderness was positive in all subjects. The active contraction test was positive in five subjects, the bench-press manoeuvre was positive in six subjects. All subjects had a positive response to the ultrasound-guided local anaesthetic injection. At the 12 week follow up, all seven subjects had resumed pre-injury level of sporting activity without pain. Clinical evaluation of the pectoralis minor muscle at this time was normal and the mean (range) Constant and Murley score measured approximately 94% (91–96%). The Wilcoxon matched pairs test showed a significant increase ($p < 0.05$) in the post-treatment Constant scores (at final follow-up) compared with pre-treatment scores.

Discussion

Weight training is an integral part of many sports. A high incidence of shoulder injuries has been reported in weightlifters, which may be a consequence of reduced professional supervision, particularly at amateur level.¹¹ This study is an analysis of clinical findings in seven cases of insertional tendinopathy of pectoralis minor. The condition is described here as “Bench-

Presser's Shoulder” because the bench-press exercise was the initiating and aggravating factor in five of the seven cases in this study. Clinical evaluation of the pectoralis minor muscle was based on anatomical palpation and resisted movement. Pectoralis minor tendon is the only major structure inserting onto the medial surface of the coracoid process. Medial coracoid tenderness would therefore indicate pathology of the pectoralis minor entheses. Pain with either the active contraction test or the bench-press manoeuvre, both involving the contraction of pectoralis minor, is also indicative of pectoralis minor muscle or tendon pathology. Confirmation of pectoralis minor insertional tendinopathy is obtained by achieving an immediate reduction or disappearance of pain after an ultrasound-guided injection of a local anaesthetic agent into the insertion site. This presentation of pectoralis minor insertional tendinopathy was treated successfully in all seven subjects in this study with a single ultrasound-guided injection of a corticosteroid into the entheses, followed by a 6 week period of relative rest and stretching, and subsequent gradual return to pre-injury level of sporting activity.

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In the August 2010 Bulletin we published a “snippet” about ACL and knee injury prevention programmes. We would like to thank the NZSOPA member who sent us this snippet from the New York Times, which talks about another aspect of knee injury management—to repair or not to repair the torn ACL? Links to a references are included.

How much does knee surgery help?



By [GRETCHEN REYNOLDS](#)

A new study published late last month in [The New England Journal of Medicine](#) is raising provocative questions about how best to treat a torn anterior cruciate ligament. For the study, researchers from Lund University in Sweden recruited 121 young adults who’d injured their A.C.L.’s. The volunteers, between 18 and 35, were physically active, and many were competitive athletes. They were randomly assigned to one of two groups and accept radically different treatments for their torn A.C.L.’s. The first group began physical therapy and then underwent surgical reconstruction of the ligament, considered by many people to be the best option for injured athletes. The second group received only physical therapy, with the option to have the operation later. Twenty-three subjects of that group did eventually have the operation. (For those fortunate enough not to be personally familiar with A.C.L. surgery, reconstruction involves replacing the injured ligament with tissue from elsewhere in your own leg or from a cadaver.)

Over two years, the injured knees were assessed using a comprehensive numerical score that rated pain, function during activity and other measures. At the time of the original injury, the knee also had been scored. At the end of the two years, both groups showed considerable improvement. The scores for the surgically repaired knees had risen by 39.2 points. The scores for the more conservatively treated knees also had risen, by 39.4 points. Despite a widespread belief that surgery leads to a stronger knee, the results showed that surgically reconstructing the A.C.L. as soon as possible after the tear “was not superior” to more conservative treatment, the study’s authors wrote. The findings suggest, the authors concluded, that “more than half the A.C.L. reconstructions” currently being conducted on injured knees “could be avoided without adversely affecting outcomes.”

By one estimate, as many as 1 in every 556 fit, active people will tear an A.C.L., particularly if they participate in sports that involve frequent pivoting and landing, like soccer, football, tennis, skiing and basketball. At the same time, the urge to treat the injury with surgery appears to be growing. The “belief among most surgeons and patients is that surgery is a ‘must,’ at least if you aim to go back into an active lifestyle,” the Swedish authors of the study wrote in an e-mail response to questions.

Part of the reason for A.C.L. surgery’s popularity is that, by most measures, it works. In the current study, most of the group who had reconstructive surgery reported that their injured knee felt healthy after two years and that they had returned to activity — not, in most cases, at the same level as before their injury, but they were active. Significantly, their knees also were notably more “stable” than the joints that hadn’t been surgically fixed. Stability is, in theory, desirable. A stable knee rarely gives way. But in practice, the importance of stability after A.C.L. treatment is “controversial,” the New England Journal study’s authors, Richard Frobell, Ph.D., and Stefan Lohmander, M.D., Ph.D., of Lund University, wrote in their e-mail.

How much does knee surgery help? (continued)...

In an important [2009 study published in the British Journal of Sports Medicine](#), researchers retrospectively compared outcomes after 10 years in competitive athletes who had surgery or had opted for conservative treatment of their torn A.C.L.'s. The surgically repaired knees were notably more stable.. But they weren't fundamentally healthier. The surgically reconstructed knees and the conservatively treated joints experienced similar (and high) levels of early-onset knee arthritis, a common occurrence after an A.C.L. tear. The treatments were almost identical, too, in terms of whether the athletes could return to sports and whether they reported subsequent knee problems.

Why, then, undergo A.C.L. reconstruction, an operation that can be expensive and, like all surgical procedures, carries risks? Several top-flight orthopedic surgeons I contacted say that they remain convinced that surgery leads to a better long-term outcome for certain patients, particularly if they want to return to pivoting sports. "The reason to have the surgery is to preserve" other parts of the knee from injury during activity, says Dr. Warren Dunn, an assistant professor of orthopedics and rehabilitation at Vanderbilt University who has extensively studied A.C.L. tears. He points out that in the N.E.J.M. study, only 8 percent of the patients in the first surgical group subsequently tore a meniscus, a fragile pillow of cartilage that can rip if a knee gives way. Twenty-five percent of those in the physical therapy group eventually tore their meniscuses.

What these numbers mean for anyone who tears an A.C.L. or is the parent of a young athlete in that situation is that they should have a long, frank conversation with an orthopedic surgeon and possibly also a nonsurgical sports-medicine specialist about options. "We recommend surgery based on activity level and sports," Dr. Dunn says. "Most subjects can do in-line activities" like running or biking "without an A.C.L." He adds, "On the other hand, we believe that A.C.L.-deficient subjects that do return" to sports involving cutting, pivoting or planting the leg "can consequently injure the meniscus" or other cartilage in the knee and would benefit from a replacement A.C.L. The authors of the N.E.J.M. study are less sure. "On the basis of our study results, we'd tell patients" that "there is no apparent downside of starting a good rehab program and waiting with the surgery decision to see if it is needed or not," the authors wrote to me.

The ultimate lesson of the N.E.J.M. study is almost certainly that more science on the subject is needed. "We definitely know only parts of the long-term outcome" after different A.C.L. treatments, says Dr. Duncan Meuffels, an assistant professor of orthopedic surgery at Erasmus Medical Center in Rotterdam and lead author of the British Journal of Sports Medicine study.



But large-scale, randomized controlled studies, the gold standard of medical research, may be difficult to orchestrate, in part because people with shredded A.C.L.'s can balk at being denied surgery. In the N.E.J.M. study, some of those assigned to physical therapy wound up requesting surgery, although they weren't experiencing any knee problems. For them, it seems, "the desire to undergo surgery was based on expectations rather than symptoms," the authors told me. It may be years, unfortunately, before we know if such expectations are justified or if unreconstructed injured knees can be fine.

Source: New York Times

Asics Gel 3010

www.asics.co.nz

Asics apparel and footwear discount for NZSOPA members. For order form [click here](#) or open attachment in this Bulletin

Asics originally developed this shoe as the Creed in 2004. Six years later it is far more refined and more comfortable for the wearer. Targeted toward runners who continue to pronate late into midstance phase of gait, the shoe's aim is to distract frontal plane forces and transform them into sagittal plane forces. There are 7 parts that make up the shoe's outsole. With smaller outsole segments there is less surface tension and it is easier to plantarflex the foot at the propulsive phase of 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 3010 has a women specific flexible trussic that allows the arch to drop freely at different rates without being irritated by the midshank.

The Dynamic Foot Cradle is a separate medial portion of EVA that is designed to guide body movement forward and distract away from pronation forces at midstance gait. Personal Heel Fit is incorporated into the heel of the shoe's upper. This is closed cell memory foam that moulds to the wearer's heel and reduces shear forces and blistering. Biomorphic material with 4-way stretch is added in the 5th MPJ point where there is high deformation in the upper. It is also placed in the medial arch of the shoes' upper to give closer fit for individual foot types. 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 3010 is a shoe that is designed for the foot type that is slow to resupinate. It aims to reduce eccentric load on the Tibialis posterior and Soleus muscles whilst keeping the shoe's weight low and making it easy to flex the foot at propulsion. This shoe functions better than previous 3000 models as the outsole has been remodelled to increase metatarsal flexibility. The shoe is now more comfortable under foot and its upper has been refined to improve wrap around fit whilst under dynamic load.



Footnote:

This shoe may prove difficult for the retailer to assess as the shoe's aim is not to reduce heel eversion moment, and most retailers look at pronation in the heel. Rather, this shoe should be analysed from behind – but looking at the timing of resupination in the foot at heel lift phase. Looking for the 'too many toes sign' on the lateral aspect of the foot is a good indicator for late midstance pronation occurring.

Monique Udjur
BigFoot Podiatry

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October 2010, Volume 40, No. 10

[RESEARCH REPORT]

Lower Extremity Kinematics of Females With Patellofemoral Pain Syndrome While Stair Stepping

Kirsty McKenzie, Victoria Galea, Jean Wessel, Michael Pierrynowski

[View abstract here](#)



[RESEARCH REPORT]

Effect of Posture on Acromiohumeral Distance With Arm Elevation in Subjects With and Without Rotator Cuff Disease Using Ultrasonography

Nitin Kalra, Ameer L. Seitz, N. Douglas Boardman III, Lori A. Michener

[View abstract here](#)



[RESEARCH REPORT]

Augmented Low Dye Taping Changes Muscle Activation Patterns and Plantar Pressure During Treadmill Running

Luke A. Kelly, Sebastian Racinais, Craig M. Tanner, Justin Grantham, Hakim Chalabi

[View abstract here](#)



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Evidence-Based

Diagnosticians

Guy G. Simoneau, Stephen C. Allison

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[RESEARCH REPORT]

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After Exercise on

Performance, Immune

Changes, and Psychological

Outcomes

Douglas L. Stacey, Martin J. Gibala, Kathleen A. Martin Ginis, Brian W. Timmons

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[MUSCULOSKELETAL IMAGING]

Ultrasound Assessment of the

Tibialis Posterior Tendon

Christopher Neville, Kelly Meyers, Leonard Hojnowski

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[RESEARCH REPORT]

Functioning and Disability in Patients With Hip

Osteoarthritis With Mild to Moderate Pain

Karin Rydevik, Linda Fernandes, Lars Nordsetten, May Arna Risberg

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[MUSCULOSKELETAL IMAGING]

Insufficiency Fracture of the Pubic Rami

Lance M. Mabry, Michael D. Ross, Michael A. Tall

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[RESEARCH REPORT]

A Comparison of Hip Strength Between Sedentary Females With and Without

Patellofemoral Pain Syndrome

Eduardo Magalhães, Thiago Yukio Fukuda, Sylvio Noronha Sacramento, Andrea Forgas, Moisés Cohen, Rene Jorge Abdalla

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NZSOPA Calendar

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3-9 October, 2010

Ironman Sports Medicine Conference

Location: Royal Kona Resort, Hawaii.

Website: [Ironman Sports Medicine Conference](http://www.ironman.com/sportsmedicine)

4-6 November, 2010

Asics Conference of Science & Medicine in Sport

Location: Mirage Resort, Port Douglas, Australia

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

12-14 November, 2010

International Conference on Applied Strength and Conditioning

Location: Gold Coast, Australia

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

18-20 November, 2010

Sports Medicine & Science Conference 2010

Location: Duxton Hotel, Wellington, NZ

Website: <http://www.sportsmedicine.co.nz/conference/index.htm>

25-26 November, 2010

NZ Strength & Conditioning Conference

Location: AUT University, Auckland, NZ

Website: [NZ Strength & Conditioning Conference](http://www.nzstrengthandconditioning.com)

29-30 November, 2010

6th National Orthopaedics and Sports Injuries Conference

Location: London, United Kingdom

Website: [6th National Orthopaedics & Sports Injuries Conference](http://www.6thnationalorthopaedicsandsportsinjuries.com)

13-15 January, 2011

Volleyball Medicine Congress, 2011

Location: Bled, Slovenia

Website: <http://www.fivbmedicine2011.org/>

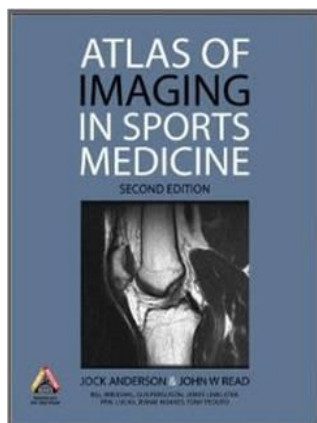
Need financial assistance to attend one of these conferences? Apply to the Asics Education Fund. [Click here](#) (use your NZSOPA login details).

**** This congress looks excellent. Karim Khan, Hakan Alfredson and more. If you're in that neck of the woods it would be well worth a look****

NZSOPA Bulletin, October 2010

Each edition of the NZSOPA Bulletin will profile one of the many membership benefits.
For a full list of membership benefits go to the NZSOPA website www.nzsopa.org.nz

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2. Click on either Physical therapy or Physical/Sports Medicine & Rehabilitation and all the relevant books will appear

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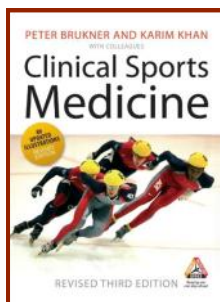
...Payment: Credit card (Mastercard or Visa)

IMPORTANT: SEND COMPLETED ORDER FORMS TO mborich@ihug.co.nz

If you have any further questions regarding this process please do not hesitate to contact Michael at the email address above.

Michael Borich
NZSOPA Secretary
mob 021717303

Book Reviews



The August issue of the NZSOPA Bulletin featured two McGraw-Hill book reviews for “Clinical Sports Medicine” and “Atlas of Imaging in Sports Medicine”. To see book reviews by NZSOPA members for McGraw-Hill books click on the following link: [Book Reviews](#)

After viewing the extensive range of titles available on the McGraw-Hill website, if there are any particular titles that you feel would be appropriate for review please let me know mborich@ihug.co.nz

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www.nzsopa.org.nz

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Your login is the email address you provided to Physiotherapy NZ.

Your password will be sent to you by email from NZSOPA. You can then re-set your password by selecting "reset password".

Having trouble? Contact the [web manager](#)



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www.nzsopa.org.nz/members1.html



(click on the item for a direct link to the web page)

- * [Clinical Forum](#) - ask a clinical question or discuss a professional issue
- * [Asics Order Form](#) - clothing and shoes
- * [McGraw-Hill Book Order Form](#) - 25% member discount on all McGraw-Hill titles
- * [Calendar](#) - upcoming conferences, courses and events
- * [Asics Education Fund](#) - information, guidelines and application form
- * [Blog](#) - recent topics
- * [Vacancies](#) - locum and job & sports team position advertisements
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Physiotherapist

Professional Services Contract

The Canterbury Rugby Football Union and the Crusaders Franchise aim to build on their positions as two of the leading and most respected rugby organisations in the world.

We are seeking a suitably qualified Physiotherapist with a proven track record of working with and supporting athletes and sports teams to be the primary provider of professional physiotherapy treatment to Canterbury Rugby Football Union Academy players. In addition, the Physiotherapist will support the Lead Physiotherapist in the provision of physiotherapy services to Crusaders and Canterbury A players to ensure that they receive the highest standard of medical services, rehabilitation, and rehabilitation.

Applicants should be qualified physiotherapists and have:

- Membership of the New Zealand Society of Physiotherapists;
- A minimum of 3 years musculoskeletal physiotherapy experience;
- Experience in working with the development of youth;
- Outstanding organisation and communication skills;

A relevant post graduate qualification would be desirable

A full position description is available on our websites at www.canterburyrugby.co.nz or www.crusaders.co.nz, and is also attached to this Bulletin (click  on at the bottom left of screen).

Please email your application, in confidence, to Raylene Palmer at raylene.palmer@crfu.co.nz or post to CRFU, P O Box 755, Christchurch 8140 **by Friday, 29 October 2010.**

