

# BULLETIN

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## Welcome to the June 2011 edition of the SPNZ Bulletin.

Once again our hearts go out to those members affected by the Christchurch earthquakes. The stress and disruption to both personal and professional life is enormous. Please let us know if there is any way we, as an Executive can assist those of you who are affected by these events.

### 2012 Sports Physiotherapy Symposium

Planning continues for our 2012 Sports Physiotherapy Symposium, being held once again at the Sebel Trinity Wharf Hotel in Tauranga on March 17th and 18th 2012. Jill Cook has been confirmed as our keynote speaker, as well as Mr Matt Brick (orthopaedic surgeon) and a range of other high quality speakers. We have also been working on a new logo for Sports Physiotherapy New Zealand following our change of name in January this year. We are close to finalising a new design and look forward to rolling this out in the near future.

### Community-based Exercise Programmes

In this edition we feature a Christchurch-based physiotherapist, letje van Stolk, who has developed community-based exercise programmes for patients suffering from long term health conditions including stroke, peripheral vascular disease and osteoporosis. The changing face of health care and the need for a more cost-effective method of service delivery means this type of programme is the way of the future. Thanks to letje for sharing her passion and ideas, and I'm sure you will all find this a very thought-provoking read.

In keeping with our main feature the Special Projects Group have summarised recent research findings relating to the benefits of exercise for long-term health conditions including rheumatoid arthritis, diabetes, peripheral vascular disease and osteoarthritis. David Rice has also summarised recent literature relating to the prevention of osteoporosis and the role of exercise therapy in prevention and management of this condition. Of interest is the role of physical activity in early childhood years in preventing this condition developing in later life. With physical activity being one of the most easily modifiable factors in osteoporosis, as well as a number of other non-communicable diseases, is it time we started addressing these issues where appropriate in our younger patients?

### Latest Research

The SPNZ President, Dr Tony Schneiders has an article published in the International Journal of Sports Physical Therapy titled "**Functional Movement Screen™ - normative values in a young, active population**", a relevant article for anyone involved in injury prevention and management in sporting teams and individuals. We also update the Bone Health, Rehabilitation, Foot and Ankle and Sports Medicine research reviews.

We always welcome feedback (good or bad!) or suggestions for our Bulletin, so please send us your feedback to [mborich@ihug.co.nz](mailto:mborich@ihug.co.nz).

SPNZ Executive.

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# IN THIS EDITION



To locate a page quickly, click on the 'pages' symbol at the top of the pdf reading panel at left of screen and select the required page.

<b>LATEST NEWS</b>	<b>3</b>
<b>SPNZ Symposium 2012</b>	
IFSP News	
IFSP Registration Board Update - Sports Physiotherapy Accreditation	
International Journal of Sports Physical Therapy	
Asics Education Fund— <b>next funding round closes <u>31st August 2011</u></b>	
<b>FEATURE</b>	<b>4</b>
<b>COMMUNITY BASED MEDICAL EXERCISE PROGRAMMES</b>	
Ietje van Stolk is a Christchurch-based physiotherapist and recipient of a Health Innovation Award for community-based exercise programmes for patients with long-term health conditions. Read about her programmes and their importance in the changing health-care environment.	
<b>CLINICAL SECTION</b>	<b>7</b>
Article Review: "Osteoporosis Prevention"	
<b>BOOK REVIEW</b>	<b>9</b>
"The Brand Called You", Author Peter Montoya	
<b>RESEARCH SECTION</b>	
<b>Sports Physiotherapy NZ Research Reviews:</b>	<b>10</b>
The Benefits of Medical Exercise for:	
- Rheumatoid arthritis	
- Diabetes	
- Osteoarthritis	
- Peripheral arterial disease	
<b>Journal of Orthopaedic &amp; Sports Physical Therapy: Volume 41, June 2011</b>	<b>13</b>
<b>Other Research Reviews:</b>	<b>14</b>
Bone Health Reviews	
Sports Medicine Reviews	
Foot and Ankle Reviews	
Rehabilitation Reviews	
<b>CONTINUING EDUCATION</b>	
National and international courses and conferences in 2011	<b>15</b>
<b>SPNZ WEBSITE INFORMATION</b>	<b>16</b>
<b>ADVERTISING</b>	<b>17</b>
<b>CLASSIFIEDS</b>	<b>19</b>

# LATEST NEWS

## SPNZ Symposium, 17<sup>th</sup> & 18<sup>th</sup> March, 2012.

Prevention, Practice Performance. Keynote speakers confirmed.

Jill Cook has been confirmed as our keynote speaker. Jill is world renowned for her work in the area of tendon research, and also for her clinical skills in putting the research into practice. Put the date in your diary and we look forward to seeing you in Tauranga next year. More updates will be available as they become available on: [www.nzsopa.org.nz/symposium.html](http://www.nzsopa.org.nz/symposium.html)

## International Federation of Sports Physiotherapy News

Keep up to date with IFSP News.

The IFSP newsletters are available to download in .pdf format from the website <http://www.ifsp-world.org/>

## IFSP Registration Board Update

Accreditation process for sports physiotherapists.

In July 2010, the first IFSP registration meeting was held among the interim Registration Board. This process allowed peer review and assessment of submissions from countries that were aiming to achieve IFSP recognition of their national professional development pathways towards specialty recognition in sports physiotherapy.

At that meeting, formal approval was given to the Sports Physiotherapy Specialty routes in Australia, UK, the Netherlands, Denmark and Ireland. The process in New Zealand was also approved pending government recognition of levels of physiotherapy specialisation. There are also a number of countries ready for registration, as well as a several others with existing pathways that may be close to submission.

This was a major step in the direction of achieving an international accreditation process for sports physiotherapists. Since then, a further meeting has taken place to discuss how this process can be developed and formalized.

## International Journal of Sports Physical Therapy

The IJSPT journal is available to purchase for individual members.

SPNZ members interested in subscribing to this journal can purchase an individual subscription through the journal directly. To purchase a subscription go to the [IJSPT website](#), and click on "[subscriptions](#)". Subscription rate

for 2011 is €20.

The current issue contains a number of high quality articles including "**Functional Movement Screen™ - normative values in a young, active population**", by SPNZ President Dr Tony Schneiders from the University of Otago. Other articles include a review on conservative management of patellofemoral pain, the predictive ability of upper limb functional tests for softball throw distance, and rehabilitation guidelines for exertional compartment syndrome. To view the current issue of the IJSPT [click here](#).

## Asics Education Fund

Need financial assistance to conduct research or attend a conference?

### **Next deadline for applications 31st August 2011.**

SPNZ offer \$1000, twice per year to members to assist with research or continuing education. Application instructions, application forms, terms and conditions are on the website [www.nzsopa.org.nz](http://www.nzsopa.org.nz), login to **Members Section** and click on **Education Grant**.

### Donations open for earthquake affected physiotherapists.

[Click here](#)

### Interested in helping SPNZ?

#### The Special Projects team could use your help.

This group help the SPNZ Executive with various 'special projects' and assist with contributions to the Bulletin. Do a little, or do lots, it's up to you.

If you're interested in helping or want to know more? Contact

[acadogan@vodafone.co.nz](mailto:acadogan@vodafone.co.nz)

# FEATURE

## COMMUNITY BASED MEDICAL EXERCISE PROGRAMMES

**Christchurch physiotherapist, Ietje van Stolk, discusses the development of community-based exercise programmes for sufferers of long-term health conditions.**

Many physiotherapists working in private practice will have been asked to treat a patient with a long-term health condition such as neurological deficit resulting from spinal cord injury or stroke, or been asked for advice about exercise for conditions such as heart disease or diabetes. In the current environment, the majority of these patients are required to travel (often) long distances back to the hospital for ongoing care, with no care provided in the local community. Some choose to pay privately for physiotherapy advice in their community however the cost of one-on-one treatment is not sustainable and these patients inevitably miss out on valuable therapy, compromising outcomes.

Ietje van Stolk recognized the need for this situation to change, and was awarded a Health Innovation Grant to pilot a community-based exercise programme, run by physiotherapists using local gymnasiums. She tells us about her programme, her results for a group of stroke patients, and patients suffering vascular disease, and her plans to extend the pilot to osteoporosis. This is a cost-effective and simple programme - read how you can help add momentum to the cause as we enter a new era of health-care delivery.

### IETJE VAN STOLK

*Christchurch Physiotherapist*

#### INTRODUCTION

Whilst working in my private physiotherapy clinic in Christchurch, I heard about a physiotherapist in the North Island who was offering a free circuit in a gym for Stroke survivors. This motivated me to do the same.

My name is Ietje van Stolk, I qualified in Amsterdam in 1981, and I have always been interested in rehabilitation. My first job was in Botswana, where I worked in two mission hospitals and a home for disabled children and after that I worked in a general hospital in the French part of Switzerland. Switzerland was followed by a short stint in Holland and after traveling around the world for two years with my future husband, we eventually immigrated to Lyttelton with our then 3 month old daughter. She is now 22 years ago and has a 13 year old brother!

Our clinic in Christchurch specializes in “chronic difficult complaints” (OOS, headaches, jaw and ear aches, dental and facial pain, recurrent back, hip and shoulder pains, hyperventilation and asthma etc.). However at times I also see stroke clients. This started after two good friends of mine had strokes. And every time I treated them, (one paid by ACC and one treated for free) I wondered what was happening with all the other stroke survivors in Christchurch after they left hospital.

We sought help from Burwood Hospital for the develop-

ment of our circuit. They had established a “circuit set up” for their clients in the hospital for which they had won a Health Innovation Award. Stroke patients are often on low incomes and live on a tight budget. We decided, therefore, to ask for a minimal contribution from the stroke patients. We donated some physiotherapy hours and my husband who owns a gym, generously donated some space in his public gym. WINZ indicated willingness to fund ongoing gym memberships for those clients who continued after the circuit. So we started with one stroke class a week. This is the extent of our original plan.

#### PILOT

Whilst developing the above, we realized that ongoing exercise for one small group of stroke patients would only benefit those few stroke patients. At that time we received an e-mail from the (then) NZSP, which announced the availability of a Health Innovation Grant. It felt like a risk to spend such a lot of time putting together a proposal, whilst there was a huge chance of receiving nothing at the end of it. Fifteen proposals were sent in from Canterbury and only four were chosen. We were one of them. We were granted \$60,000. I believe that we were given the grant because our proposal is cost effective and very simple and therefore easy to reproduce nationally. All that is needed is physiotherapists who are happy to work together with a public gym in their community.

Our rationale is as follows: There are many stroke victims (500 a year in Christchurch alone). For many of these patients their daily environment is their home situation and the hospital (due to frequent visits). Because of their

## COMMUNITY BASED MEDICAL EXERCISE PROGRAMMES

limited physical (and in many cases also cognitive) ability, many of them adopt a very sedentary lifestyle. This severely weakens them over time. As we can never supply ongoing exercise for the hundreds of stroke victims who need it, we decided to pilot the following set-up.

We offer a 10-week circuit program, for a maximum of 10 stroke patients per circuit /hour. In these 10 weeks they learn which exercises are particularly beneficial for them and how to practice these exercises. They learn that exercising in a public gym is possible, and they will, therefore, develop more confidence in relation to integrating in the "non-disabled world". From session four onwards, they are encouraged to start thinking about how they are going to continue their exercise once the ten-week circuit is finished. We supply them with several options, such as continuing in our gym at set times when we set out the circuit (this has the benefit of ongoing social contact) or continue in a gym close to their home. We then liaise with that gym to ensure that they are supported with the right kind of exercise. This has the obviously important practical benefit of less travel time and, therefore, more chance that they keep going long term.

We are aware that even if we can report some objective physical changes after 10 weeks of exercise, this can hardly be called a far-reaching outcome if the client is allowed to return to their sedentary lifestyle. Therefore, our main outcome measurement is the percentage of clients that are still involved in regular exercise six months and 12 months after completing the circuit.

The above set-up is relevant for stroke patients but will also be beneficial to patients with vascular disease and osteoporosis. Vascular patients (Intermittent Claudication), because of the fact that exercise causes them pain which stops them engaging in vigorous exercise and osteoporosis patients, because they often have a lack of

understanding about the kind of exercise that is best for them. To pilot these three groups constitutes a rather big project. However it has the advantage that we will discover which kind of group can most benefit by achieving the most major change in exercise behaviour. For all three groups there is a major benefit in relation to less spending of the health dollar in terms of reduced hospital care due to increased general health, fewer falls due to increased strength and proprioception and less need for ongoing care due to avoiding the development of general weakness.

### OUR OBJECTIVES

Our primary objective is to assess the effectiveness of the provision of physiotherapy-guided circuits/classes in a public gym setting to encourage sustained exercise and improved health outcomes for three groups of patients, namely those with vascular, stroke and osteoporosis related problems.

Additional objectives are:

- To introduce exercise which is specific to the patient's health problem and which has maximum impact in relation to functionality in daily life (i.e. for our stroke patients we emphasise exercises that improve their independence in relation to getting up from a chair, walking, balance, etc.)
- To inspire confidence in relation to doing exercise in a public setting.
- To introduce planning for ongoing exercise and to ensure maintenance of health and fitness.
- To measure our success in relation to ongoing exercise with the help of a follow up after six months and again after one year. We will measure five groups of 10 patients per disease group; 50 stroke patients, 50 Intermittent Claudication patients and 50 Osteoporosis patients (a total of 150 patients).



*Pictures of participants in letje's community-based exercise classes.*

# FEATURE

## COMMUNITY BASED MEDICAL EXERCISE PROGRAMMES

### RESULTS SO FAR

#### STROKE PILOT

- 73% rate of continuation of exercise at 6 months follow up for the 41 who finished the programme (a year has not passed yet for all of them).
- A 56-58% physical improvement in relation to timed up and go and functional reach and 67% improvement in relation to walking distance (reported physical gain of 34 filled out feedback sheets 79%)
- A 18% drop out rate
- A wealth of encouraging feedback (with reported significant emotional gain 68% and small gains 11% also totalling 79% of 34 feedback sheets)
- Already existing interest from the community in organizing more of these programmes

**We conclude that our pilot for exercise in the community for stroke clients has been a success**

#### VASCULAR CLIENTS

We have the results from the first 21 Intermittent Claudication patients. The walking distance (WD) is the distance they can walk in the gym on arrival and at the last session. The walking impairment questionnaire (WIQS) is filled in by them, so that is how they perceive their own improvement. At the end of the pilot we will also have the measurements from the vascular nurses from Christchurch Hospital from all the patients who attended their follow up in the hospital.

Most clients walked at least 3-4 times their original distance (only 3 clients did not improve). One client perceived himself as much improved (WIQS from 60 to 36) but was not able to show that when he was assessed (WD from 360 to 310 m.) And one client showed improvement with his walking distance (WD from 290 to 400 m.) but did not perceive any improvement (WIQS from 42 to 43). Other than these two patients, their own ideas about improvement and their walking distance are matching reasonably well.

**We are very happy with the overall improvement and the resulting atmosphere of enthusiasm during the classes. Without this program, most of these clients would still be very sedentary because of their misunderstanding about the pain ("it hurts, so I'd better give it a rest"). Not only does that reduce their walking distance further and further, it also significantly increases their already heightened chance of a CVA**

#### OSTEOPOROSIS PILOT

That group is only going to be started now. (The Earthquakes have definitely resulted in delays)

#### THE FUTURE

We obviously still have to finish our pilot. However the difficulty of finding ongoing funding is very clear, because we do not have any to date for our Stroke group. Initially we received funding to continue our programme from the PHO, but when the CCN (Canterbury Clinical Network) was started all discretionary funding had to be stopped. "Where do I go now for funding?" I asked. The CCN but they would not be ready to process any funding requests for at least a year I was informed. I believe that I had a really good chance to receive funding from the CCN flexible funding pool by July, but due to the earthquake it has all been put on hold.

Yet, we are still going! A while ago we were phoned by the hospital about a young stroke victim (aged 50) who was to be sent home but had nowhere to go for further rehabilitation as he could not afford private physiotherapy. When he arrived at our class and saw what we were doing there, he and his carer were in tears. So how can I stop I ask myself.?

#### WHAT CAN PHYSIOTHERAPISTS AROUND THE COUNTRY DO TO HELP ?

What I envisage is for New Zealand to become like Holland, where the clients are so familiar with "exercise in the community groups", that after their heart attack, stroke, hip replacement etc. they do not have to be referred because they take the initiative themselves to find a group. That can only be achieved by a whole lot of us offering these programmes to the public. And we have to show the decision-makers how much this is needed. The question of funding is also imperative. It is not easy, but if it weren't for the earthquakes, I believe I would have had funding by July. We have a physiotherapy group here who work very hard on behalf of the Canterbury physiotherapists, to have physiotherapy more prominent in the "primary care world" and we are starting to make good progress.

I am happy to share my initial business plan, funding request and the final result reports. I have already offered this to all physiotherapists in Canterbury, and I am happy to offer that nationally as well.

Email; [ietje@oos.co.nz](mailto:ietje@oos.co.nz)

## ARTICLE REVIEW

## Osteoporosis Prevention

Osteoporosis is among a growing epidemic of non-communicable diseases, for which physiotherapy has a critical role to play within the multidisciplinary team in both exercise and falls prevention. David Rice has reviewed two articles for this edition of the Bulletin, dealing with important aspects of osteoporosis prevention, as well as the therapeutic effects of exercise on bone cell activity. The article references can be found at the end of this review.

**ABSTRACT**

**Background:** Patients with osteoporosis suffer from the morbidity and mortality associated with resultant fractures. The number of persons at risk for fractures is increasing as the US population ages. One of the articles reviewed addresses preventive strategies that can be used to decrease the risk of minimal trauma fractures, the other provides an understanding of the biologic mechanisms and the available clinical evidence supporting the role of exercise in bone health.

**Recent findings:** Dietary and lifestyle modifications, screening to identify individuals most likely to benefit from pharmacologic interventions, resistance exercise, falls prevention programmes have all been identified as important components of osteoporosis prevention. Exercise downregulates sclerostin expression by the osteocyte favouring osteoblastogenesis. These changes are enhanced by dynamic cyclical load with rest periods and may be promoted by low-amplitude high-frequency stimuli. In the prepubertal years, exercise results in periosteal gains, whereas exercise later in life maintains bone mass, reduces falls and probably associated fractures, and improves quality-of-life measures.

**Summary**

The ultimate goal of implementing a multipronged osteoporosis preventive program is to improve function and quality of life in later life. Future studies should examine the effect of exercise on bone strength and determine the minimum quantity and frequency and the exercise type most effective to reduce osteoporotic fractures.

**Introduction**

As primary health care professionals and strong advocates for the benefits of exercise, physiotherapists have a major role to play in the prevention of osteoporosis. These reviews highlight the need to incorporate preventative strategies into our daily practice, rather than waiting for our patients to turn up at hospital with a serious fracture. Importantly, prevention of osteoporosis occurs throughout the life span (even in the womb!). Although exercise has a key role in osteoporosis prevention, a multifaceted approach to prevention is recommended.

**Early intervention is key!**

Peak bone mass is attained in our teenage years and is important to the subsequent risk of osteoporosis. Although much of the focus on osteoporosis prevention occurs later in life, we have the opportunity to intervene much earlier, when the skeleton is still maturing. Modifiable factors that affect peak bone mass in childhood include in utero development, diet and physical activity. With respect to in-utero development, maternal smoking, vitamin D-deficiency and a lack of exercise during pregnancy have all been shown to have a negative effect of fetal bone formation. In childhood, adequate dietary intake of calcium is essential. As the peak calcium accretion rate occurs around age 12.5 in girls and age 14 in boys, dietary intervention in these age groups is particularly important. There is good evidence that exercise in children increases bone mineral density, and that those who exercise the most have the highest

bone mineral density. There is also evidence that childhood bone mineral density carries over into adulthood. It has been estimated that the development of osteoporosis is delayed by 13 years if young adult peak bone mass is 10% higher than the mean.

**The role of calcium and vitamin D supplements**

In adults, combined calcium and vitamin D supplements can increase bone mineral density and reduce the risk of fractures. Interestingly, neither calcium nor vitamin D appear to be effective when taken alone. Importantly, Calcium and vitamin D are not as effective as other pharmacological interventions and are not sufficient in patients with established osteoporosis.

**Other risk factors - Smoking and alcohol consumption**

Smoking has clear adverse effects on bone mineral density and risk of fractures, especially of the hip. The relationship between alcohol consumption and bone mineral density is less clear. Moderate alcohol consumption may have a protective effect, while excessive alcohol consumption, especially beer (!), appears to have a negative effect on bone mineral density. Patients should be encouraged to quit smoking and avoid excess alcohol consumption.

**Exercise is important, but what type?**

Bone remodeling occurs in response to the forces ap-

## ARTICLE REVIEW CONTINUED...

plied to the bone. Basic science has shown that both muscle contraction and weight bearing are important in generating the right kind of forces. To illustrate this point, bone mineral density is more strongly associated to fat free muscle mass than total body weight, or fat mass. However, professional cyclists, although producing large muscle forces, have lower bone mineral density in their hip and other sites than even non-athletes. Thus, it appears that a combination of the forces due to weight bearing activities and muscle contractions is important for bone remodeling. According to the reviews, we still don't know what the "ideal" exercise programme for osteoporosis prevention is. They do however, provide some guidance.

**Any exercise is good**

Walking programs with a duration ranging from 6 to 24 months have been shown to significantly increase bone mineral density in the femoral neck. In a large study, exercise, defined as self-reported walking, was associated with a 30% reduction in risk of fractures. A Cochrane Review analyzed 18 RCTs in postmenopausal women and reported that aerobic, weight-bearing and resistance exercises all improved bone mineral density of the lumbar spine compared to no exercise.

**Multimodal exercise may be better**

Combining higher impact exercise (e.g. jogging, step aerobics) with low impact or resistance training may have a superior effect on bone health than single modality training. Meta-analyses have shown that programs combining random impact exercise (i.e. activities with lots of acceleration/deceleration and changes of direction, like tennis) or high-impact exercise with resistance training increase bone mass at the hip and spine, whereas high-impact activity alone only promote hip bone density. Amongst post menopausal women, 18 months of high intensity multipurpose exercises led to significant bone mineral density gains at the lumbar spine and femoral neck and a reduced fall rate compared to a low-intensity, low-frequency exercise program. A recent meta-analysis of high impact exercise on bone density concluded that combining higher impact exercises such as jogging with low-impact exercise such as walking, stair climbing or resistance training effectively preserved bone mass in postmenopausal women.

**Treating the bone only goes so far...**

Falls prevention is also an important component of osteoporosis management, as it may reduce the risk of fracture. This is particularly important in older age groups, as balance begins to decline rapidly. Muscle strengthening, functional balance training and specific interventions

such as Tai Chi may help to reduce the risk of falls.

**How should we screen our patients for osteoporosis?**

There are a variety of instruments to screen for osteoporosis. One of the most commonly used is the FRAX, developed by the World Health Organization. FRAX uses up-to-date, evidence-based estimates of fracture risk and was created for the purpose of quantitatively integrating numerous risk factors into a clinically useful prediction model. The risk can be calculated with or without the femoral neck bone mineral density measurement at the website [www.shef.ac.uk/FRAX/](http://www.shef.ac.uk/FRAX/).

Direct measures of bone mineral density have also been used as a means of predicting future fracture risk. Bone mineral density measurements are recommended for women aged 65 years and older and men aged 70 years and older, or sooner for those who have clinical risk factors (e.g. glucocorticoid use, history of recent fracture) The World Health Organization's definition of osteoporosis is of a bone mineral density of the spine, hip or wrist that is 2.5 SDs or more below the reference mean (a T score of -2.5 or less).

**When is pharmacological intervention appropriate?**

There are a number of different pharmacological interventions available from the GP for patients with established osteoporosis or with a high risk of developing it. A T score of -2.5 or less OR (using the FRAX calculator) a 20% or greater 10-year risk of a major osteoporotic fracture or a 3% or greater 10-year risk of a hip fracture are suggested as the thresholds for pharmacological intervention, based on international guidelines.

**REFERENCES:**

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# BOOK REVIEW

## The Brand Called You

Author Peter Montoya with Tim Vandehey

### Make Your Business Stand Out in a Crowded Market.

**Year:** 2009  
**Publisher:** McGraw-Hill

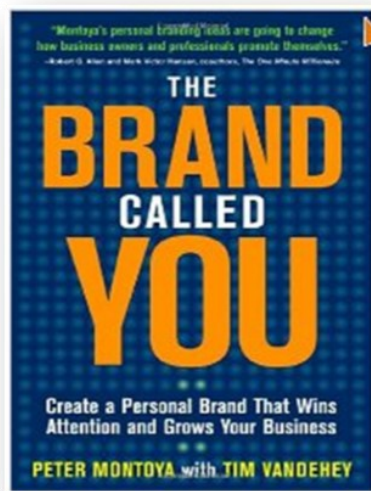
**Softcover:** 275 pages  
**ISBN No:** 0-07-159750-6

This book has been written for general business but its contents can readily be adapted to the marketing needs of the sports and orthopaedic physiotherapist.

The American authors instil an air of confidence in all that there is about making yourself and your business into a "Personal Brand" which they define as "a clear, powerful, compelling public image" i.e. who you are, what you specialise in doing, how you convey that to the public and how they perceive you. Perhaps the enthusiasm and positivity portrayed is just what we need in the present climate of political uncertainty with respect to the avenues that lay ahead for ACC and privatisation.

This first edition is an "easy to read" book divided into four parts comprising a total of 15 chapters. The introduction is nothing exciting so it's easier to breeze along to Part 1, "The DNA of a Personal Brand" which defines a brand, how that personal brand works and how to attract and maintain your best clients. Some good points are made such as having a focus on your customer type and clarification between myths, perception and reality which is very important. However, there are some suggestions that we in the health profession must balance out eg physio's can't just "ditch the losers" without due consideration of ethical responsibility!!! A reminder that the importance of having a balanced lifestyle via implementing successful changes to your business is also a valid and salient point.

Part 2 begins by looking at specialisation, a path that sports physiotherapy will tread down in the near future alike our Sports Physician colleagues. In fact, this process has already begun in other areas with specialised Pilates clinics and the odd "corporate" clinic. There are a lot of "Sports Physio" clinics as such, but at present, these also cater for general physio needs. So the emphasis on specialisation, notwithstanding the need for academic criteria, should be read with more than intrigue. Other chapters look at client/customer satisfaction and "branding channels" which are methods of promotion such as advertising, networking and referral systems all of which are covered in more detail in Part 3.



"The Anatomy of a Personal Brand" is the topic of Part 3, a more detailed look into identifying your own brand via personal/company logos, using the internet, brochures, networking, referral systems and advertising i.e. getting your brand "out there" without necessarily forcing it onto people. We all know "Where Everyone Gets a Bargain" and I'm

sure we can all recognise instantly the logos of Shell (currently being re-branded), Microsoft Coca-Cola and Google. Most people in small business are aware of many, if not all, of the areas covered but this Part extrapolates and reinforces such avenues which creates awareness.

Finally, Part 4 entitled "It's Alive, Bring Your Brand to Life in 12 months", takes you through creating, launching and maintaining your brand, a virtual summary and collation of the previous chapters that serves to get you goal orientated and organised – budgeting, target markets, timetables and customer relationship management are

systematically presented.

This book is not a tedious read, is not full of marketing jargon and is interspersed with numerous shaded "boxed areas" which illustrate a) reminders ("Things you can do in a week/month....") which make implemented and/ or desired changes seem manageable and b) case studies, although most of these studies do come across as "rags to riches" tales of large businesses.

So whether you are starting out in your business or have been practising for some years, this book can provide easy reading and then used as a reference to reinforce your business as a personal brand but bearing in mind that branding /rebranding is only one method of increasing your business. It may even encourage you to do a small business course or invite business personnel to your in-service meetings. Your business plan will never be the same!

Bharat Sukha  
Physiosport  
Auckland.

## RESEARCH SECTION

### SPNZ PHYSIOTHERAPY RESEARCH REVIEWS

#### MEDICAL EXERCISE—THINKING OUTSIDE THE CLINIC.

The face of health care is changing. Hospital bed shortages, projected workforce shortages, an ageing population and dramatic increases in rates of non-communicable diseases mean changes are required to the way health care services are delivered. This presents physiotherapists with an opportunity to diversify their practice by thinking “outside the clinic”.

Exercise has long been known to be of universal benefit to both the healthy, the unwell, and the injured. Supervised exercise programmes and group exercise programmes delivered in the home, residential care facilities, and in the community are largely unexplored health-service delivery methods in this country, all of which have proven effective in achieving improvements in patient quality of life, function and independence. The SPNZ Special Projects team have summarised some of the literature on the benefits of exercise for a variety of medical conditions.

[www.nzsopa.org.nz/resources.html](http://www.nzsopa.org.nz/resources.html)

Reviews by Wayne Fausett, Monique Baigent, Nathan Wharerimu and Amanda O'Reilly.



#### Non-pharmacological treatment of rheumatoid arthritis.

Vliet Vlieland, TPM, & van den Ende, CH. (2011). *Current Opinion in Rheumatology*; 23: 259–64.  
doi:10.1097/BOR.0b013e32834540fb

#### Article Summary

The aim of this narrative review was to summarize the available research on non-pharmacological conservative treatment for patients with rheumatoid arthritis (RA). The recommendations for exercise issued by the American College of Sports Medicine are adults over 50 with a chronic condition and/or functional limitation should complete at least 30 minutes of moderate-intensity activity daily or vigorous-intensity for at least 20 minutes on three days each week. They also recommend resistance training, flexibility and balance exercises aimed at falls prevention and joint health. RA patients can improve aerobic capacity, muscle strength and functional ability by engaging in land-based or water-based dynamic exercise programmes in less than three months. This review summarized that training should exceed 55% of their heart rate max and muscle strengthening exercises should start at 30–50% of maximal strength. Supervised and individualized strength exercises produce large gains in muscle strength and moderate effects on functional ability compared to controls. Specific hand strengthening has also shown to be beneficial, significant improvements in hand force can be gained after 6 weeks of exercise.

Education programmes for RA patients have shown to improve disease activity, pain and self and social management. Foot orthotics and wrist working splints have shown to significantly improve pain and function. Comprehensive occupational therapy (including education, ergonomic reviews, exercises, footwear, splinting, and assertive communication) has shown to significantly improve functional and work-related outcomes in RA patients. The effects of dietary manipulations in RA are still uncertain.

**Clinical Significance:** The recent literature on non-pharmacological care in RA shows that exercise programmes need to be at least six weeks duration and should be supervised, individually-tailored interventions. Factors that improve adherence are the use of participant handbooks and educational handouts, progress reviews and provision by the same trained professional. Interventions should be made up of regular aerobic, resistance, flexibility and balance training. Education and psychological interventions i.e. cognitive behavioural therapy are beneficial for many patients with RA, particularly when it comes to increasing physical activity levels.

# RESEARCH SECTION

## SPNZ PHYSIOTHERAPY RESEARCH REVIEWS CONTINUED.....

### **The effects of aerobic, resistance, and combined exercise on metabolic control, inflammatory markers, adipocytokines, and muscle insulin signalling in patients with type 2 diabetes mellitus.**

Jorge M, de Oliveira V, Resende N, Paraiso L, Calixto A, Diniz A, Resende E, Ropelle E, Carvalheira J, Espindola F, Jorge P, Geloneze B. (2011) *Metabolism*. doi:10.1016/j.metabol.2011.01.006

#### **Article Summary**

This study compared the effects of aerobic, resistance and aerobic and resistance combined exercise modalities on metabolic control, insulin resistance, inflammatory markers, adipocytokines and tissue expression of intermediates of the insulin signalling pathway. Forty-eight participants were randomized into four groups: aerobic (n=12), resistance (n=12), combined (n=12) and control (n=12). All groups undertook sixty minutes of supervised exercise three days a week for twelve weeks. The resistance group did a strength training circuit focusing on the large muscle groups. The aerobic group cycled at a pre-determined heart rate corresponding to their lactate threshold. The combined group performed resistance and aerobic training at the same intensity but half the volume of the other groups. The control group performed a stretching program three times a week. All four groups had a decrease in blood pressure, fasting plasma glucose, and postprandial plasma glucose and lipid levels. The only differences between groups were an IRS-1 expression increase by sixty-five percent in the resistance group and ninety percent in the combined group.

**Clinical Significance:** All four groups displayed decreases in blood pressure, fasting plasma glucose, and lipid profile. A clinically important finding was the important increase in the IRS-1 expression after training in the resistance and combined groups. This increase can improve insulin sensitivity. Caution needs to be used when analysing this study secondary to small sample size and most patients had adequate metabolic control, hence the impact of exercise may be less clear.

### **Supplementing a home exercise programme with a class-based exercise programme is more effective than home exercise alone in the treatment of knee osteoarthritis.**

McCarthy CJ, Mills PM, Pullen R, Roberts C, Silman A, Oldham JA. (2004). *Rheumatology*:43: 880-886  
doi:10.1093/rheumatology/keh188

#### **Article Summary**

This single blind RCT reported the added benefits of group exercise classes, over a solely home-based exercise programme (HEP) for knee osteoarthritis (OA). 225 subjects with established knee OA were randomised to either a HEP only group or HEP and 2 x 45 minute exercise circuit classes a week, for 8 weeks. The HEP was a progressive, individualised programme designed to increase muscle strength and endurance, and proprioception. Subjects were assessed for walking pain (VAS), locomotor function (timed 8m walk, stair ability, sit to stand), and WOMAC index, immediately post-intervention, with 6 and 12 month follow up. There were significantly greater improvements in the 'class' group for locomotor function and pain, which was maintained at 12 month follow up. 151 subjects were included in the final analysis, with participants excluded for undergoing either knee steroid injection or arthroplasty, or for non-adherence to the HEP and not attending the follow up reassessment.

**Clinical Significance:** The reasons for the greater improvements in the 'class' group are not clear. Could it have been the 16 extra exercise sessions, which, presuming both groups did the same amount of home exercises, would offer a greater stimulus for muscle adaptation? If it is a case of "more is better", then why not just give more home exercises? No direct measures of muscle performance were taken, so it is not known if there were strength differences between the groups. There is a point where adherence to an HEP diminishes, therefore being part of an exercise group may improve adherence via some form of psychological benefits. If that is the case, then spacing the group exercise sessions over a longer time period (6 months?) maybe a more cost-effective approach. The primary outcome measure involved locomotor activities performed at "self-selected, comfortable pace". These activities would be difficult to standardise, and the participants may have performed faster in the testing situation compared to everyday life in an effort to please the investigators. In summary, some promising results and hopefully more research to come in this area.

# RESEARCH SECTION

## SPNZ PHYSIOTHERAPY RESEARCH REVIEWS CONTINUED.....

### **Supervised exercise training reduces plasma levels of the endothelial inflammatory markers E-selection and ICAM-1 in patients with peripheral arterial disease.**

Saetre T, Enoksen E, Lyberg T, Stranden E, Jørgensen JJ, Sundhagen JO, Hisdal J. (2011). *Angiology*;62:301-305  
DOI: 10.1177/0003319710385338

#### **Article Summary**

This study examined the effects of a supervised exercise program on vascular inflammation in people with peripheral arterial disease. Twenty nine subjects underwent walking, cycling and weights exercises two times a week for 8 weeks. Their levels of three different endothelial inflammatory markers were measured pre and post intervention. In addition a treadmill test was done to measure pain free and maximum walking distance before and after treatment. The results indicated a significant reduction in two of the inflammatory markers and a significant increase in both walking parameters after 8 weeks of exercises.

**Clinical Significance:** This study demonstrated quite nicely the beneficial effects of exercise at a cellular level. The testing consisted of blood sampling at inclusion then again at 8 weeks. It was not made clear how long after the last exercise session that the subjects were tested. Previous studies have already demonstrated an immediate reduction in inflammatory markers post exercise that can last up to a few days so it is unclear whether the results from this study were because of the 8 weeks of exercise or a more recent effect of the previous day's activities. Perhaps a clearer criteria of how much activity was done in the time before testing could have been set out and controlled for. Otherwise an interesting study that really adds to the base of support for exercise therapy in peripheral vascular disease.

### **Exercise and Type 2 Diabetes Mellitus - Move Muscles More Often!**

Dunstan D. (2011). *Nat Rev Endocrinol*;7:189-190  
DOI: 10.1038/nrendo.2011.35

#### **Article Summary**

This article summarises new guidelines from the American College of Sports Medicine and the American Diabetes Association regarding specific exercise for individuals with Type 2 Diabetes Mellitus (DM) published in 2010. The guidelines were developed in a joint position statement derived from review of numerous high quality studies conducted over the previous 10-year period. While the position statement reiterates what we already know, that physical activity is the cornerstone of prevention and management of Type 2 DM, it adds specific new information regarding exercise doseage for those with, or at risk of this condition. The recommendations call for at least 150 minutes of moderate-intensity aerobic exercise every week, and brisk walking was deemed an appropriate 'moderate-intensity' activity for most people with Type 2 DM. This should be spread over at least 3 days with no more than 2 consecutive rest-days between exercise bouts.

The guidelines state that aerobic exercise alone cannot deliver the full benefit of exercise, and that strength training is highly effective in managing Type 2 DM, and is the only form of exercise that will prevent age-related loss of muscle mass, strength and function. It is recommended that resistance exercise of moderate to vigorous intensity should be undertaken at least twice, preferably 3 times weekly on non-consecutive days. Recent research suggests that the combination of aerobic and resistance training results in significantly improved glycaemic control compared with either of these performed in isolation. Research also suggests that sedentary occupational or recreational behavior, even when recommended exercise doseages are being met, will independently increase metabolic risk.

**Clinical Significance:** Once again, the benefits of combinations of aerobic and resistance training exercise have been highlighted. With obesity on the rise, it is the role of every health professional to provide appropriate preventative advice. As physiotherapists, we should be incorporating these exercise parameters into rehabilitation programmes and encouraging at-risk patients to make habitual exercise and lifestyle changes in an effort to reduce burden on future health care services. This also means education about finding more opportunities to be 'active' during the day including taking stairs, walking the extra bus stop and even increasing standing (vs sitting) time at the office. Physiotherapists are ideally placed to provide individualized programmes tailored to the individuals physical abilities.

## RESEARCH SECTION

## JOURNAL OF ORTHOPAEDIC &amp; SPORTS PHYSICAL THERAPY



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June 2011; Volume 41, Issue 6

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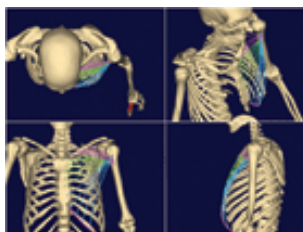
[ RESEARCH REPORT ]

**Utilization of Modified NFL Combine Testing to Identify Functional Deficits in Athletes Following ACL Reconstruction**



Gregory D. Myer, Laura C. Schmitt, Jensen L. Brent, Kevin R. Ford, Kim D. Barber Foss, Bradley J. Scherer, Robert S. Heidt Jr., Jon G. Divine, Timothy E. Hewett

**Computer Simulation of Pectoralis Major Muscle Strain to Guide Exercise Protocols for Patients After Breast Cancer Surgery**



Caroline W. Stegink-Jansen, William L. Buford Jr., Rita M. Patterson, Lisa J. Gould

**The Immediate Effects of Muscle Energy Technique on Posterior Shoulder Tightness: A Randomized Controlled Trial**

Stephanie D. Moore, Kevin G. Laudner, Todd A. McLoda, Michael A. Shaffer

**The Relationships Between Inter-recti Distance Measured by Ultrasound Imaging and Abdominal Muscle Function in Postpartum Women: A 6-month Follow-up Study**

Lih-Jiun Liaw, Miao-Ju Hsu, Chien-Fen Liao, Mei-Fang Liu, Ar-Tyan Hsu

[ EDITORIAL ]

**Asymmetrical Lower Extremity Loading After ACL Reconstruction: More Than Meets the Eye**

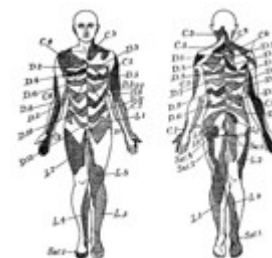
Terese L. Chmielewski

[ PERSPECTIVES FOR PATIENTS ]

**Return to Sport: When Should an Athlete Return to Sport After an ACL Surgery?**

[ CLINICAL COMMENTARY ]

**Conflicting Dermatome Maps: Educational and Clinical Implications**



Mary Beth Downs, Cindy LaPorte

[ MUSCULOSKELETAL IMAGING ]

**Posttransplant Distal Limb Syndrome**

Joseph A. Shrader, Galen O. Joe

**Cystic Fibrosis Dysplasia of the Humerus**

Ashley H. Burns, Reg B. Wilcox III

[ RESIDENT'S CASE PROBLEM ]

**Occult Hypermobility of the Craniocervical Junction: A Case Report and Review**

K. Sean Mathers, Michael Schneider, Michael Timko

[ NEW PRODUCTS ]

**June 2011 New Products**

A selection of products and developments of interest to JOSPT readers.

**NEW: Practice Guidelines**

[Achilles Pain, Stiffness and Muscle Power Deficits](#)

# RESEARCH SECTION

## RESEARCH REVIEWS

Register (FREE) and download the latest “NZ Research Reviews”

<http://researchreview.co.nz>



### Studies in this issue:

- Cumulative alendronate dose and the long-term risk of femur fractures
- Thiazolidinediones and fracture risk
- Sex hormones and BMD in older men
- Failure to perceive increased fracture risk in older women
- Predicted hip fracture incidence in NZ
- Patterns of treatment after fracture in Australian men
- Odanacatib improves BMD in postmenopausal women
- Evaluation of FRAX and Garvan fracture risk calculators
- Calcium supplementation and the risk of atherosclerotic vascular disease
- Height loss is an indicator for vertebral fractures



### Studies in the latest issue include:

- Exercise and type 2 diabetes
- Identifying patellofemoral pain patients likely to benefit from foot orthoses
- Rotator cuff tendinopathy: pathology and related management
- A–Z of nutritional supplements: part 13
- Foot orthoses and gait
- Kinesiotape and calf function, pain and motoneuronal excitability
- Acute anterior cruciate ligament tear treatments
- Sports concussion and chronic neurological impairment
- Cervical spine stabilisation techniques



### Studies in this issue:

- Obese children: flat and fat feet
- Patellofemoral pain syndrome: foot posture and kinematics
- Customised insoles: effects on plantar pressures
- Optimal casts for plantar foot ulceration
- Rheumatoid arthritis and impact of forefoot bursae
- Foot orthoses reduce injury in Military personnel
- Chronic gout affects gait
- Photographs reliable for diagnosing foot ulcers
- Foot orthoses beneficial in patellofemoral pain syndrome



### Studies in the latest issue include:

- Keep exercising in multiple sclerosis.
- Peer support promotes physical activity in heart disease.
- Evidence-based cognitive rehabilitation. Knowledge brokering in children’s rehabilitation organisations.
- Goal Management Training for executive functioning deficits.
- Aphasia worsens quality of life after stroke. Obesity interventions for people with a learning disability.
- Understanding permanent post-concussion symptoms.
- Facing the huge financial challenges in the NHS. What constitutes good quality care for the disabled?

<http://www.researchreview.co.nz>

# CONTINUING EDUCATION

Upcoming courses and conferences in New Zealand and overseas in 2011 and 2012.

[www.nzsopa.org.nz/calendar.html](http://www.nzsopa.org.nz/calendar.html)

## LOCAL COURSES & CONFERENCES

When?	What?	Where?	More information
<b>2011</b>			
19 June	STOTT PILATES Athletic Conditioning on the Reformer Workshop	Auckland	<a href="mailto:info@corepilates.co.nz">info@corepilates.co.nz</a>
21 June	STOTT Pilates - Advanced Reformer	Auckland	<a href="mailto:info@corepilates.co.nz">info@corepilates.co.nz</a>
25 & 26 June	PAANZ Conference 2011	Auckland	<a href="http://www.paanz.org.nz/">http://www.paanz.org.nz/</a>
25 June	Polestar Pilates - Mat 2	Wellington	<a href="http://polestarpilates.co.nz/forms.php">polestarpilates.co.nz/forms.php</a>
25 June	Kinesio Taping Course KT 3	Dunedin—Replacing Christchurch course	<a href="http://www.kinesiocourses.co.nz/courses">www.kinesiocourses.co.nz/courses</a>
2 July	Polestar Pilates—R3/S3	Wellington	<a href="http://polestarpilates.co.nz/forms.php">polestarpilates.co.nz/forms.php</a>
16 July	NZMPA - Cervical Spine Upgrade Course	Auckland	<a href="mailto:admin@nzmpa.org.nz">admin@nzmpa.org.nz</a>
6 & 7 August	NZ Manipulative Physiotherapists Association Knee and Exercise Prescription	Wellington	<a href="http://nzmpa.org.nz">nzmpa.org.nz</a>
27 & 28 August	NZ Manipulative Physiotherapists Association Biennial Scientific Conference: "The Role of Exercise in Management of Musculoskeletal Pain &	Rotorua	<a href="http://nzmpa.org.nz/2011-conference">nzmpa.org.nz/2011-conference</a>
<b>2012</b>			
March 17 & 18	Sports Physiotherapy NZ "Prevention, Practice & Performance"	Sebel Trinity Wharf, Tauranga	<a href="http://www.nzsopa.org.nz">www.nzsopa.org.nz</a>

## INTERNATIONAL COURSES & CONFERENCES

When?	What?	Where?	More information
<b>2011</b>			
24 -26 June	Discover the Sports Thorax—LJ Lee	Sydney	<a href="http://physiohealing.com.au">physiohealing.com.au</a>
19-22 October	Australian Conference of Science and Medicine in Sport	Freemantle, Perth	<a href="http://ACSMS Conference">ACSMS Conference</a>
27-30 October	Australian Physiotherapy Association 2011 Conference	Brisbane	<a href="http://physiotherapy.asn.au/conference2011/">http://physiotherapy.asn.au/conference2011/</a>
10-12 Nov	Discover the Sports Pelvis—LJ Lee	Sydney	<a href="http://physiohealing.com.au">physiohealing.com.au</a>
<b>2012</b>			
30 Sep - 5 Oct	IFOMPT 2012: Rendez-vous of Hands and Minds	Quebec, Canada	<a href="http://www.ifomptconference.org">www.ifomptconference.org</a>

# SPNZ WEBSITE

## SPNZ MEMBER SECTION

[www.nzsopa.org.nz/members.html](http://www.nzsopa.org.nz/members.html)

<p><b>Login</b></p> <p>Email  <input type="text" value="Insert your email address"/></p> <p>Password  <input type="text" value="Password provided by SPNZ"/></p> <p><a href="#">Reset password</a></p> <p><input type="button" value="Sign in"/></p>
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Your email address is that which you supplied to Physiotherapy NZ.

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## NEW TO THE MEMBERS SECTION:

Copies of all clinical article reviews and SPNZ Research Reviews that appear in the SPNZ Bulletin editions will be placed in the new "Resources" section, as well as an updated list of Open Access Journals. These will be available for

### [SPNZ's Research Reviews](#)

- Osteoarthritis
- Injuries in Cricket

### [List of Open Access Journals](#)

(full text available to all members)

- Sports physiotherapy
- Sports medicine
- Sports science
- Rehabilitation

### [Clinical Article Reviews](#)

- Barefoot running and the minimalist shoe debate
- Bench pressers' shoulder—overuse tendinosis of pectoralis minor
- Blood clots and plane flights
- Breathing pattern disorders in athletes
- Case report—lateral ankle fracture and missed proximal tibiofibular instability
- Efficacy of injury prevention related coach education in soccer and netball
- Heat acclimatization guidelines for high school athletes
- Management of hamstring injuries—issues in diagnosis
- Sideline evaluation of bone and joint injury
- Ocular injuries in basketball and baseball

## Quick Links to Members Section

### [Resources](#)

Copies of SPNZ's Research Reviews, a list of open-access journals (full-text available), clinical article summaries and other sports physiotherapy related articles.

### [Vacancies](#)

Sports Team Positions and Clinic Positions available

### [Clinical Forum](#)

Got a clinical question and want advice from members? Post your question on the clinical forum.

### [Asics Education Grant Information](#)

Application form, guidelines and instructions



### [Book Reviews](#)

Book reviews on sports physiotherapy topics

### [Snippets](#)

Quick sports physiotherapy tips

### [Calendar](#)

Calendar of upcoming courses and conferences

### [Reports](#)

Minutes of SPNZ meetings and submissions on professional matters.

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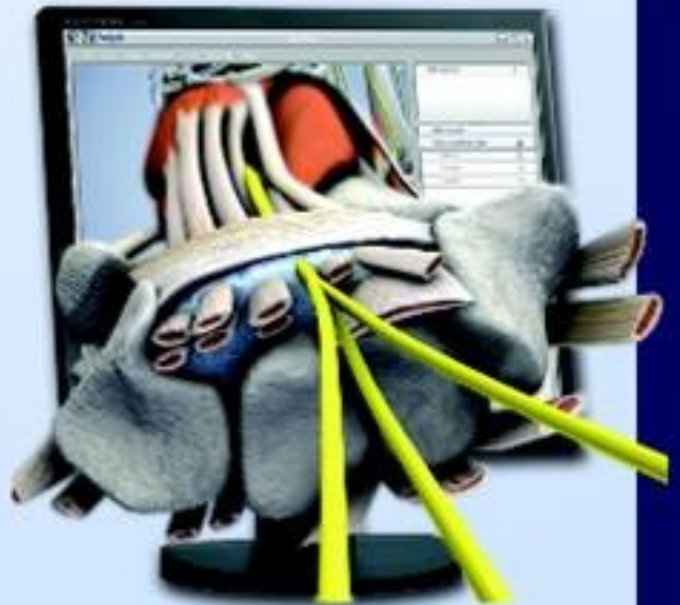
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Date: Thursday the 11th of August, 2011

Venue: AUT, North Shore, Akoranga Campus, Theatre AF114

Time: 7.00pm Registration 7.30pm sharp start – 9.00pm finish

Early Bird Rate: \$20 AUD Early Bird until June 18th, 2011

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Webpage [www.bbclasses.com.au](http://www.bbclasses.com.au)

Direct link [http://www.bbclasses.com.au/agent\\_courses.php?agent=9](http://www.bbclasses.com.au/agent_courses.php?agent=9)

Enquiries: [liz@bbclasses.com.au](mailto:liz@bbclasses.com.au)

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Date: Sunday the 14th of August, 2011

Venue: NZ - New Plymouth, Taranaki, New Zealand, Lecture Theatre (Level 3) & Physiotherapy Department (Level 2), Taranaki Base Hospital, 27 David Street

Time: 8.30am registration, 9.00am start – 5.30pm finish

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# CLASSIFIEDS

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## PRIVATE PRACTICE POSITIONS

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### NELSON - CENTRAL

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Margreet Hofman (Practice Manager)  
at Sports Therapy, Nelson.  
Tel. 03 548 1221

[sportstherapy@132physiotherapy.co.nz](mailto:sportstherapy@132physiotherapy.co.nz)

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### MOUNT MAUNGANUI

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**Body in Motion Physio & Rehab**

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We have four base clinics within Tauranga, Mt Maunganui, and Papamoa with a dedicated team of 20 experienced physiotherapists. Each clinic has onsite gym facilities. The clinics are supported by friendly efficient administration staff.

We currently hold Vocational, Pain Management, and the

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The position would ideally be suited to a physiotherapist with 3-5 years+ experience, holding post-graduate qualifications in Sports Physiotherapy and/or Manipulative Physiotherapy. A rehab bias would be beneficial. All applications will be considered.

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For further information please contact Mal Shivnan on 0274820997 and/or email CV to [mal.shivnan@bodyinmotionphysio.co.nz](mailto:mal.shivnan@bodyinmotionphysio.co.nz)

## PRACTICE FOR SALE

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