

for every physio who cares

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Hands on

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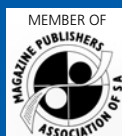
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The message is wrong

"The fitness industry itself does not even know what health is. The so called 'fitness professionals' have completely lost the definition of health. Somehow we have perverted what the word health is. There is an overriding belief that the measure of health is somehow related to appearance."

Physiotherapist **Chloe Hoeben** posted an article called *The Most Important Thing I Have Ever Written*, by coach Taylor Simon, on the SASP Facebook page recently, and I read it with my head nodding violently.

I wrote a review late last year of *Natural Born Heroes* by Chris McDougall, who writes about George Hébert, the early 20th century man who, before World War I, developed the *Méthode Naturelle* (Natural Method) of training, with the motto 'Être fort pour être utile' (be strong to be useful). "Instead of lifting weights repetitively, running for hours, or chasing a ball, his trainees would learn to climb a tree, shinny up a pole, lift and carry a human body, throw a stone. They would develop a fitness that was ready for action, ready for surprises; a fitness that was not aimed at winning trophies or measuring muscle, but aimed at 'being useful'..."

Taylor Simon would agree with that principle: fitness of the kind we achieve in the current model is not useful – it is, as he says in that extract, primarily related to appearance – abs so defined it looks unnatural, 'cut' bodies without a sliver of fat on them, bulging biceps.

What is a healthy body?

Can you assess someone's health from what they look like? Does beauty equal health?

Of course not. And physiotherapists are well-placed to know that!

My aunt Freda was a ballet dancer, so talented that she is mentioned in the History of Ballet in South Africa. But she could never be a prima ballerina, she explained to me, because she had the family calves (which I too have inherited): rather than being long and elegant, her legs were short and very muscular. Instead, she

trained a whole generation of prima ballerinas. And she was fit enough to outlast many a young person, well into middle age and beyond – in her sixties, she did 'movement classes' at an old age home and was shocked when she realised that many of the people there, confined to wheelchairs, were her age or even younger.

She had a healthy body – one that served her well, keeping her walking up Table Mountain's slopes until she died of cancer in her 70s.

My father's body (muscular calves and all) was no competition for Channing Tatum (although he became a weightlifter to build some upper body strength). But his body saw him through all the deprivations of prisoner of war camp in Germany and a long life thereafter. When he was already in his seventies I watched him lift a tumble-drier in his arms with little visible effort.

The UK's Lindsey Swift, size 18, was put on the cover of *Runner's World* after being taunted by a van driver while running. She wrote a Facebook post which included these really pertinent words: "I am not ashamed of my body. It has never stopped me from doing anything I want. My fat body has done things that you, hanging out of the window of your babe-magnet white van, could only ever dream of. My fat body has been swimming in crystal clear Thai seas that you have probably only ever seen on TV. It has lived in countries you wouldn't dream of visiting and been a part of cultures you are too small-minded to appreciate. My fat legs have carried me up mountains on more than one occasion. My fat brain speaks languages you probably don't see the point of learning, which is why you spend your time hanging out of van windows since you have nothing better to occupy it with."

We're swimming in bad messages

But that one cover of a running mag is small beer compared to what's on the covers of magazines like *Men's*

Can you assess someone's health from what they look like? Does beauty equal health?



Health, the ubiquitous images which surround us night and day. Those chiselled abs and biceps take dedicated daily hours to develop – and for some men it's an impossible dream.

Promoting these goals put people off fitness: "The new attitude that fitness is only effective if you barf during training and cannot walk normally for days has combined with the bollocks belief that the leaner the body is the healthier it is.

This has created an even larger misconception amongst the population as to what true health and fitness truly is."

And the creation of this mythology around fitness stops people in their tracks. If you think that the only way to be fit is to lose weight by exercising like a Big Loser contestant, how long will you last? If you think the only way to be healthy is to have a torso like Hugh Jackman playing Wolverine, you're likely to give up now. Yet images of people like these are the water we swim in, the wallpaper of our lives. In fact, it's even worse – images of people who already have bodies beyond the dreams of most of us and in addition have been Photoshopped and airbrushed and enhanced are everywhere, on billboards, on our laptops, on TV, on our phones. And how does that help to boost fitness, to promote bodies that are fit for purpose?

In fact, I even question the Fitbit model of fitness, the measuring and counting and obsessing. It might incentivise people into repetitive actions that score, but will it make their bodies more useful and pleasant to live in over the long-term?

People stick over a lifetime with exercise – or rather, activities that happen to be physical – if they enjoy them for more than the score and the sweat accumulated, if they become part of their lives and part of their leisure time with friends and family, not stuff that demands hours of commitment and barfing! Instead of counting steps, people would be better off planning walks with the dogs, Frisbee with the kids, a pick-up game of soccer with friends.

Instead of setting people up to fail with a relentless barrage of impossible goals, what physiotherapists and others thinking in terms of public health need to aim

for is getting people to love using their bodies. We need to

create a vibe, a social milieu, in which playing ball games and roughhousing and hiking and making your own coffee table out of pallet wood are more fun and more cool than Playstation and Facetime.

And to do that, as Simon points out, we need to be very aware of the messages and images we send out. Are all the people in the posters in our practices young and beautiful? Or if they're older, are they impossibly fit and gorgeous, just a wrinkle here and there and elegant white coiffures? Why don't we make a concerted effort to celebrate the diversity of bodies we all know that are 'fit for purpose', even if they're not gorgeous? Let's make a space in which real people can see themselves reflected back at them instead of feeling cowed and hopeless because what they see all over the place is beyond their grasp. ✨

If you think that the only way to be fit is to lose weight by exercising like a Big Loser contestant, how long will you last?

Defining fitness

Simon cites three definitions of fitness:

The condition of being physically fit and healthy.

The quality of being suitable to fulfill a particular role or task.

An organism's ability to survive and reproduce in a particular environment.

Number two: that's it. That's really it. Is your body up to doing what you want to do, what you need to do and what you enjoy doing?



Racism, transformation and the physiotherapy profession

Lynn Fearnhead and Mandi Smallhorne ask readers to reflect on some important questions

"Although transformation is multidimensional, its primary aim is to redress, consciously and proactively, the inequalities of the past [...] the physiotherapy profession and professionals, have a moral obligation to systematically address the legacy of discrimination wherever and however this is reflected [...].the question that needs to be asked at this stage is: who is 'the profession' and who should be driving this transformation agenda? (Mbambo N, 2005)

The country is in an uncomfortable state as we write this article. News headlines are screaming about destruction and damage; social media is awash with complex cross-currents of anger. In amongst the sturm und drang, important issues have been raised: in a country where less than ten

percent of the population is white and about 80% is black, has transformation been moving at too slow a pace, so much so that many young people see that the doors of opportunity remain wide open for white youngsters, while they've only opened a crack for black youth?

The issue of real transformation, of real change to the status quo, has been raised, and in the wake of #Rhodes-MustFall, #FeesMustFall and all the other hashtags and protests of recent months, it is important that we ask ourselves some difficult and penetrating questions.

And first and foremost is that question posed by Nonceba Mbambo (now Professor Mbambo-Kekana): "Who is 'the profession', and who should be driving this transformation agenda?"

P5 ►

Science

Cutting edge

Stay current with our digest of musculoskeletal science

Biomechanical response of lumbar facet joints under follower preload: a finite element study


Cheng-Fei Du et al
BMC Musculoskeletal Disorders DOI: 10.1186/s12891-016-0980-4 15 March 2016

Abstract

Background: Facet joints play a significant role in providing stability to the spine and they have been associated with low back pain symptoms and other spinal disorders. The influence of a follower load on biomechanics of facet joints is unknown. A comprehensive research on the biomechanical role of facets may provide insight into facet joint instability and degeneration.

Method: A nonlinear finite element (FE) model of lumbar spine (L1-S1) was developed and validated to study the biomechanical response of facets, with different values of follower preload (0 N, 500 N, 800 N, 1200 N), under loadings in the three anatomic planes. In this model, special attention was paid to the modeling of facet joints, including cartilage layer. The asymmetry in the biomechanical response of facets was also discussed. A rate of change (ROC) and an average asymmetry factor (AAF) were introduced to explore and evaluate the preload effect on these facet contact parameters and on the asymmetry under different loading conditions.

Result: The biomechanical response of facets changed according to the loading condition. The preload amplified the facet force, contact area and contact pressure in flexion-extension; the same effect was observed on the ipsilateral facet while an opposite effect could be seen on the contralateral facet during lateral bending. For torsion loading the preload increased contact area decreased the mean contact pressure, but had almost no effect on facet force. However, all the effects of follower load on facet response became weaker with the increase of preload. The greatest asymmetry of facet response could be found on the ipsilateral side during lateral bending, followed by flexion, bending (contralateral side), extension and torsion. This asymmetry could be amplified by preload in the bending (ipsilateral), torsion loading group, while being reduced in the flexion group.

Conclusions: An analysis combining patterns of contact pressure distribution, facet load, contact area and contact pressure can provide more insight into the biomechanical role of facets under various moment loadings and follower loads. The effect of asymmetry on facet joint response should be fully considered in biomechanical studies of lumbar spine, especially in post structures subjected to physiological loadings. 



Some history

"...the crux of thinking historically about the present: there is an inescapable tension between what is imposed and what remains possible [...]" (Bundy 2014)

"Men make their own history, but they do not make it just as they please; they do not make it under circumstances chosen by themselves, but under circumstances directly encountered, given and transmitted from the past." (Karl Marx)

The physiotherapy profession, like many others in this country, was slow to recognise the need for openness and inclusivity, slow to move towards transformation, but moves were made even before the new democracy arrived.

Molly Levy, (past President of the SASP) was largely responsible for changing the wording of our Board Registration conditions, thereby giving all physiotherapists first line practitioner status in 1985.

Thought was given to the role of a medical professional under apartheid, and especially in those very difficult years: "Guidelines for members of the SASP concerning the treatment of prisoners, political detainees and/or victims of unrest the guidelines were published by the NEC in 1989 and includes 'the patient at all times retains his rights as a patient, including the right to receive the best possible care'." (Faure 1995)

Support for Africa

In 1991, the World Confederation of Physical Therapy (WCPT) Africa Region was established. The SASP was a founder member of both WCPT and the Africa Region and has been very supportive of WCPT Africa since its inception. Indeed, some South Africans have been the Africa region representative on the WCPT, such as the current rep, Joyce Mothabeng, and Zola Dantile (whose sterling career saw her become president of the SASP and has now led her to chair the Health Professions Council Board for Physiotherapy, Podiatry and Biokinetics).

The SASP has worked hard to open up opportunities in the field to those denied access to a physiotherapy qualification – the organisation funded workshops led by Linky Molatoli for the Professional Board for Physiotherapy, Podiatry and Biokinetics which resulted in the development of the qualification programme for Physiotherapy Technicians.

Back in 2003, under the guidance of Zola Dantile and her National Executive Committee (NEC), the SASP bucked the current trend in medical fields to kick against community service. "It's going to happen, it should happen, so let's make it the best and most effective system possible," was Zola's attitude. The SASP was thus very supportive of the HPCSA PPB Board's change in the

"The legacy of apartheid cuts deep within the physiotherapy profession. Physiotherapists are facing a great challenge to bridge the gap between black and white professionals and in this way unite the profession.

White physiotherapists may expect the profession to forget the past and move forward but for the black physiotherapists, confession is not enough and if it does not involve critical reflection and positive action to make amends. It is only when real change takes place within the profession that they will be able to let go and forgive."
(Molatoli 1999)

registration of new physiotherapy graduates and the introduction of community service – and put in place a support structure for the increased numbers of newly graduated physiotherapists working in rural areas.

Access to education

Since 2001 the Education Committee of the SASP has awarded grants to financially assist disadvantaged physiotherapy students to continue their studies at university. These Marjorie Catt awards are named after the member who bequeathed a share portfolio to the SASP. The Society has used the annual dividend to fund these grants. By early 2011 R290,000 had been distributed from this source alone. The Education Trust was then registered in November 2011. Between 2012 and 2015 the Education Trust, the SASP Marjorie Catt and the South Gauteng Marjorie Catt have awarded bursaries worth R717,000.

The SASP developed and ultimately approved a new constitution on 2 June 2001. This process was essentially aimed at uniting the administration of the SASP with PhysioFocus. However, another significant objective was to try to ensure that the Society was as inclusive as possible. To that end a category of 'demographics' representatives were included in the National Assembly. These were the student, male, disabled, black and foreign-trained members: it seems like a rather blunt instrument with hindsight, but it was well-intentioned and an important step forward!

The 2015 Strategic Planning meetings for Physiotherapy were broadly inclusive of physiotherapists in South Africa mandated to identify key weaknesses and threats and seek potential for change and opportunity for development. Among those weaknesses and threats – but also opportunities for growth – was the rapidly changing environment in South Africa.

The SASP has used its conferences and publications to promote ethical practice and transformation within the profession.

Difficult questions

"Who is 'the profession', and who should be driving this transformation agenda?"

In 2016 to what extent...

1. Has this question been answered ?
2. Do we measure change in transformation ?

We also have to ask why membership has not become more diverse. Do black physiotherapists not feel welcome? Is it too expensive for public sector physios? And finally, when will it be possible for the SASP and the



“The TRC document (the Physiotherapy submission to the Truth and Reconciliation Committee of 1998) states that the physiotherapy profession lacked a culture of human rights.” (Molatoli 1999)

newly registered Physiotherapy Association of South Africa to really talk to each other about together representing the needs of all our members and providing services to the people of South Africa?

Facing up to these and other difficult questions may be painful and tough – but it will also open up some huge opportunities for personal and organisational growth, healing and a better, more integrated and in-touch profession. ✨

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Science

And in other news...

Hands On brings you relevant science news from other health disciplines

Salt of the earth

Is salt bad for you? The obvious answer is Yes, of course, we know that... one of the most common pieces of dietary advice given is to lower salt.

We tend to accept, about this and other bits and pieces of ‘received wisdom’, that the research has been done and the verdict is in. But has it? Salt research received a bit of a going-over recently from an article in the International Journal of Epidemiology, co-authored by Ludovic Trinquart, Columbia University Epidemiology Merit Fellow at the Mailman School of Public Health with doctoral student David Johns and Sandro Galea, Dean of the Boston University School of Public Health and adjunct professor of Epidemiology at the Mailman School.

This is not to make a judgement call on whether salt is or isn’t a Bad Thing – as the article makes clear, we really don’t have a definitive answer on that. It’s just worth pointing out the dynamics that lie behind much research in areas like nutrition and drugs. It would, as the authors say, be fascinating to see this method applied to other areas.

An analysis of scientific reports and comments on the health effects of a salty diet reveals a polarization between those supportive of the hypothesis that population-wide reduction of salt intake is associated with better health and those that were not. In all, 54 percent were supportive of the hypothesis; 33 percent, not supportive; and 13 percent inconclusive.

[...]

The researchers systematically reviewed 269 academic reports published between 1979 and 2014, including primary studies, meta-analyses, clinical guidelines, consensus statements, comments, letters, and narrative reviews. Each was classified according to whether it supported or refuted the link between reduced sodium intake and lower rates of heart disease, stroke, and death. More than half of the reports were published since 2011—suggest-

ing an increasing level of interest in the question, even if there was no emerging consensus.

A citation analysis found papers on either side of the hypothesis were more likely to cite reports that drew a similar conclusion than to cite reports drawing a different conclusion. Dominating the literature were a small number of influential papers that presented strong evidence for and against.

“There are two almost distinct bodies of scholarship—one supporting and one opposing the claim that salt reduction in populations will improve clinical outcomes,” says Johns. “Each is driven by a few prolific authors who tend to cite other researchers who share their point of view, with little apparent collaboration between the two ‘sides.’”

“We pay quite a bit of attention to financial bias in our work,” says Galea. “We seldom pay attention, however, to how long-held beliefs bias the questions we ask and the results we publish, even as new data become available.”

An analysis of systemic reviews revealed very little consistency in the selection of primary studies. If a primary study was selected by a review, the chance that another review would select the same study was less than a third. The finding points to uncertainty and disagreement about what should count as evidence, the authors argue. Moreover, choices about which studies to cite as primary evidence directly influenced the conclusions of systematic reviews.

Even while the scientific debate over salt continues, public health officials, from the local to the global level, have enacted policies to lower consumption. [...]

In the future, the same method could be applied to other topics, including controversial issues such as e-cigarettes as well as topics on which there is greater agreement. ✨

(From Columbia University Mailman School of Public Health, 18 February 2016)



Mythbusting the McKenzie method of Mechanical Diagnosis and Therapy

Ian Grey with a little straight talk

For many years, in South Africa, the McKenzie Method of Mechanical Diagnosis and Therapy (MDT) was merely a chapter at university or a quick glance at Robin McKenzie's work on a course. If you were lucky enough, you or someone you know attended a course long ago or had the opportunity to attend a part of the educational process overseas. But more recently the efforts of a few passionate individuals has seen McKenzie courses become common occurrences on the yearly South African calendar, as more and more therapists have started spreading the word.

As with any new concept introduced into a country, common myths concerning MDT have been perpetuated by incomplete or inaccurate information being transferred from individual to individual. This phenomenon is not unique to South Africa, and many of these myths are spread by international opinion, often turning into unfounded criticism of the method. I will attempt to touch on the most common of these myths surrounding MDT and hopefully shed a little light on these misunderstood areas.

Myth #1: It is only an exercise regime.

The McKenzie Method is a comprehensive system, and its assessment forms the foundation for further clinical reasoning, directing treatment appropriately to individual patient's conditions. This assessment is commonly overlooked as patients and therapists alike find the solution to their or their patient's problem and share this miracle cure with other individuals, who might or might not respond to similar treatment strategies. Nikolai Bogduk commented in the foreword of Robin McKenzie's *Lumbar Spine* textbook that: "Its reliability is now beyond doubt. Whereas research has shown that other methods of assessment lack reliability, McKenzie assessment has moved from strength to strength." (McKenzie and May, 2003).

Myth #2: McKenzie is all about extension.

The McKenzie system is well known for the three main mechanical subgroups that can be identified; the Derangement, Dysfunction and Postural Syndromes. By far the most prevalent and well-known subgroup within the McKenzie system is the Derangement Syndrome. The fact that this subgroup's prevalence is so high in muscu-

loskeletal disorders leads to its popularity with a similarly high number of patients who respond to extension-based regimes (May and Aina, 2003).

The reality is, however, that even if we ignore both other subgroups, within this Derangement subgroup of patients other directions of movement, force progressions of these movements, alternative loading mechanisms, mid-range movement and static loads should be considered as evaluation tools and possible treatment options. It is important to mention that Nikolai Bogduk added a second comment to the previous quote, stating: "While anyone can assess according to the system, it cannot be mastered by hearsay or assumption." (McKenzie and May, 2003)

Myth #3: The system is Hands Off.

A unique feature of the MDT system is that it uses a principle where forces are progressed, starting with patient-generated forces with the option to gradually build up through therapist-generated forces, including manipulation where required. This force-progression principle not only serves as a built-in safety mechanism, but also serves to empower the patient to self-manage and become independent of the therapist. Education forms the basis for the interaction between therapist and patient, with the therapist using hands-on techniques where patient-generated forces are not sufficient to effectively manage the condition. Using manual therapy, patients can be helped to again gain control of their own symptoms as patient-generated forces become effective once more (McKenzie and May, 2003).

Myth #4: McKenzie is all about the disc.

It is true that the Centralisation phenomenon recognised within the system and also first described by Robin McKenzie was deemed to correlate extremely well with diagnostic injections implicating the disc as source of pain. (Donelson et al. 1997) It is, however, not the only

The McKenzie Method forms the foundation for further clinical reasoning, directing treatment appropriately to individual patient's conditions.



More and more research is being published describing the system's application in the upper and lower limb

response evaluated in the spine and not the only finding that guides treatment.

Other Syndromes where Centralisation is not recognised as a feature are also identified with the assessment and in recent years it has been demonstrated that therapists with an appropriate level of training are also able to apply the method with very good reliability in peripheral

joints (Abady et al. 2014, May and Ross 2009). More and more research is being published describing the system's application in the upper and lower limb with several case studies, and one Randomised Controlled Trial on knee pain (Aina and May 2014, Lynch and May 2013, Menon and May 2012, Rosedale et al. 2014).

Myth #5: The McKenzie approach ignores Biopsychosocial factors.

Not all patients fit one of these three Mechanical syndromes; however MDT is a comprehensive system and there are OTHER subgroups identified in the system that include a subgroup identified by psychosocial factors or neurophysiological changes as primary contributors to the patient's pain experience. In-depth training on these subgroups takes place later during the educational process; the comment is common among clinicians who only have a basic knowledge of the system. In fact the focus on patient empowerment and achieving self-efficacy through education forms the cornerstone to MDT's strong bio-psycho-social nature. In 2014 Takasaki et al. performed a study in Japan and concluded that therapists credentialed in MDT were significantly more guideline-consistent and displayed a more biopsychosocial treatment orientation than their peers.

Myth #6: The McKenzie method it is out-dated.

Robin McKenzie first observed the Centralisation phenomenon in a patient now referred to as 'Mr. Smith' in 1952, and this timeframe may lead some to considering the idea to be old. This per chance discovery started Robin down a path where he observed specific responses in patients, in response to simple loading strategies allowing him to develop the system we now know today. This did not happen overnight and Robin spent about 60 years refining the system until the time of his death in 2013.

In 1982, Robin founded the McKenzie Institute for the purposes of furthering his research and educating more clinicians in the approach. It is through this structure, which Robin put in place, that further refinement and adjustments to the classification system have been implemented, as recently as 2015, to better accommodate new

research findings in our constant search for improved patient care (The McKenzie Institute Educational committee, 2015). No other clinically induced symptom response has been the subject of so much research as the Centralisation phenomenon, recognised by Robin so many years ago (May and Aina, 2012).

It is pertinent to the correct implementation of any concept that the user has a good understanding of the concept's principles; therefore the Institute offers a standardised and structured educational programme that allows clinicians time to assimilate and integrate their knowledge into their clinical practice. The sequence of training facilitates advanced courses to serve as opportunities for including every individual's experiences into the learning process. These post-graduate courses are followed by a credentialing exam in order to demonstrate the clinician's competency in MDT. Clinicians who successfully completed the credentialing program are eligible to apply for admission to the masters-level Diploma Programme, to achieve the highest level of competence in Mechanical Diagnosis and Therapy. ✨

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Cutting edge

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of musculoskeletal science

Vitamin D and knee pain

Vitamin D supplementation for individuals with knee osteoarthritis and low 25-hydroxyvitamin D levels did not reduce knee pain or slow cartilage loss, according to a study appearing in the March 8 issue of JAMA.

Symptomatic knee osteoarthritis occurs among 10 percent of men and 13 percent of women age 60 years or older. Currently there are no disease-modifying therapies for osteoarthritis. Vitamin D can reduce bone turnover and cartilage degradation, thus potentially preventing the development and progression of knee osteoarthritis. Observational studies suggest that vitamin D supplementation is associated with benefits for knee osteoarthritis, but current evidence from clinical trials is contradictory.

Changhai Ding, M.D., Ph.D., of the University of Tasmania, Hobart, Tasmania, Australia, and colleagues randomly assigned 413 patients with symptomatic knee osteoarthritis and low 25-hydroxyvitamin D to receive monthly treatment with oral vitamin D3 (50,000 IU; n = 209) or an identical placebo (n = 204) for 2 years. The study was conducted in Tasmania and Melbourne, Australia.

Of 413 enrolled participants (average age, 63 years; 50 percent women), 340 (82 percent) completed the study. The researchers found that vitamin D supplementation, compared with placebo, did not result in significant differences in change in MRI-measured tibial cartilage volume or a measure of knee pain over 2 years. There were also no significant differences in change of tibiofemoral cartilage defects or change in tibiofemoral bone marrow lesions. Vitamin D levels did increase more in the vitamin D group than in the placebo group over 2 years.

"These data suggest a lack of evidence to support vitamin D supplementation for slowing disease progression or structural change in knee osteoarthritis," the authors write. 🦋

(*ScienceDaily*, 8 March 2016)

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Where to contact us:

Should you want to find out more about the benefits we can offer, or the cost of our services, you are welcome to contact Phillip Potgieter personally by email at philip@hpaudit.co.za or visit our website at www.dataspoton.co.za. Follow us on Facebook and Twitter to join the conversation - search using 'dataspoton'.

Witness for the profession

The new SASP deputy president has a powerful basket of skills and talents to bring to the position

We have Celie Eales to thank for the acquisition of Professor Witness Mudzi by South Africa. The physiotherapy stalwart and long-time editor of the *South African Journal of Physiotherapy* met Witness when she was an external examiner at the University of Zimbabwe, where he, too was an examiner.

Witness had graduated with a BSc Physiotherapy Honours degree from the University of Zimbabwe in 1996. He then worked as a part time physiotherapy lecturer at the University of Zimbabwe from 1997 while working full time as both physiotherapist and Head of Department at Ruwa National Rehabilitation Hospital.

“Why don’t you come to Wits and do your Masters?’ Celie said to me.” The idea stayed in Witness’ mind and when Celie broached it again a year later, he made up his mind to do it.

“I came down to the University of the Witwatersrand in 2000 and got my Masters in 2001,” he says, not mentioning that this was cum laude. “I did a lot of academic teaching, and I just loved everything. I thought, I could easily make this my home.” He joined to the University of Zimbabwe in a lecturing post for a couple of years, but then decided he needed to get his doctorate. “The only place to do that was Wits, so I returned in 2004 and started my doctorate the next year. And now this is the only home I know!”

Published papers

Witness’ passion lies in adult neurological rehabilitation, and he has more than 20 published papers under his belt. “My research interest in adult neurology is exploring functional recovery and the related impact on patients’ quality of life.” He got his doctorate in 2010, and in 2014 was made Associate Professor. Students love him – he’s been awarded Outstanding Mentor and best lecturer over the years – and he has been very involved guiding science done at Wits as the Postgraduate and Research Coordination for the Department of Physiotherapy. “I am also currently the Chair of the School of Therapeutic Sciences’ Postgraduate and Research Committee. I serve on various portfolios in the Faculty of Health Sciences. I am involved in the assessment of PhD protocols at Faculty level and MSc protocols at school level as well.” He was recognised for dedication and achievement in research at the Faculty of Health Sciences Research Awards dinners in 2012 and in 2014.



SASP commitment

Witness also serves on the Research Foundation Committee of the SASP, screening applications for research funding. He was Chair of the Professional Development Portfolio of the South African Society of Physiotherapy (SASP) from 2013 to 2016.

“I’ve been working within the SASP at various levels, since 2008, and am involved in a number of sub-committees as well, such as Quality Assurance and the Journal.”

Witness was happy to be nominated for the Presidency: “I have realised that I do have a lot to offer,” he says. “The Society is a wonderful place to be to influence the direction in which the profession is going. There are a number of threats to us in the current environment that need to be dealt with adequately.”

One such threat – and opportunity – is the looming advent of National Health Insurance. NHI is going to come, no doubt about it, Witness says, and the profession needs to be positioned correctly for this. “One area we have neglected as a profession is our role in primary health care – which is going to be the foundation of the NHI. We need to be seen as an active participant in PHC. We do have the training, of course, but we must be seen and understood to have a role – the fact that people don’t see it means we’re not getting the message across!”

Work in prevention at PHC and all levels is crucial, he adds. “We need to change our mind-set and start looking at how we can prevent major public health problems like

low back pain – before they start. We really need to do a bit more of this kind of intervention.”

Witness is concerned that the profession should fix this misperception now, well before NHI starts to be rolled out. “If we’re not occupying this terrain now, it will be very difficult to force ourselves in when it’s all in place.”

A recognised force

His aim is to achieve a brand of physiotherapy of which all physiotherapists can be proud, and see the profession become a force recognised for its value by both patients and other healthcare professions. “We need to be an evidence-based profession which has a vision and looks to the future,” he says. Ensuring that all physiotherapists work with the most up-to-date trends and follows the best research in the world means ensuring that it is easy for all members of the Society to have easy access to continuing professional development opportunities. “We can and must play a more active role in providing these opportunities,” he says.

Happily married, Witness has three children, two boys with a huge gap between them (the eldest is in his second year at Varsity while the second-born is in Grade R!) and a girl of 18 months – “my little darling,” Witness says fondly. He’s a died-in-the-wool family man who loves to spend his leisure time with his family and friends. And I’m sure they will join us in giving him support and cheering him on as he embarks on this new and exciting phase in his career! 🌟

Will you be there?

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WHAT World Confederation of Physical Therapy Congress

WHERE Cape Town International Convention Centre,
South Africa

WHEN 2-4 July 2017

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Physiotherapy for Stress Urinary Incontinence

Bettina Moser, Women's Health Physiotherapy Group course committee member, wrote this for the newsletter of the South African Urogynaecology Association, on which she is a representative. Worth reading!

Isolated stress urinary incontinence (SUI) accounts for half of all urinary incontinence (UI), with most studies reporting a 10% to 39% prevalence rate. It has a huge impact on quality of life (QOL), with high financial, social and emotional costs. Exercise of the pelvic floor musculature has been part of Chinese Taoism for 6000 years but it entered modern medicine in 1936, when Margaret Morris introduced contracting and relaxing of the pelvic floor to the British physiotherapy profession. Arnold Kegel in 1948 reported on its success for SUI. Our current

evidence is such that there is level 1 evidence supporting supervised and intensive pelvic floor muscle training in SUI with a 60-70% subjective cure and improvement rate. (*Dumoulin 2014; Berghmans 2013*)

The anatomy of the continence system can be organised into those structures that provide normal support to the lower urinary tract and those that determine urethral closure force. The main anatomic hypotheses for development of SUI are firstly, the loss of structural support, that is, around the bladder neck and urethra. Secondly,

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the hammock theory whereby the urethral support is constant but compression from the pelvic floor and fascia is decreased. Thirdly, the neural hypothesis is related to pudendal nerve injury.

The total urethral closing mechanism is twofold, an intrinsic urinary sphincteric closure mechanism and an extrinsic urethral and vaginal wall support mechanism. The intrinsic closure mechanism is compromised by atrophy of tunica mucosa and spongiosa caused by oestrogen deficiency in menopause or dysfunction of the tunica muscularis due to surgery. The extrinsic support mechanism is related to well-functioning supportive structures. The major supportive structures are the vaginal wall, endopelvic fascia, arcus tendineus fascia pelvis and levator ani muscles. (Ghaderi 2014, Berghmans 2013).

Risk factors

Risk factors for the development of SUI include child-birth, age, decreased collagen content and elasticity, race and ethnicity, obesity, smoking, chronic cough, respiratory diseases, pelvic surgery, chronic constipation, and carbonated drinks. Furthermore, there are also some nonspecific risk factors, such as pelvic organ prolapse, medication, fluid intake, fecal incontinence, and pelvic pain, which may result in SUI.

It is worth mentioning that the co-existing pelvic symptoms might be as follows: dual incontinence and pelvic organ prolapse, constipation, sexual dysfunction, chronic pelvic pain, low back pain, and hip pain. (Dumoulin 2014)

The biological rationale behind pelvic floor muscle training (PFMT) for SUI is twofold. Firstly, an intentional, effective pelvic floor muscle contraction (lifting the pelvic floor muscles in a cranial and forward direction) prior to and during effort or exertion clamps the urethra and increases the urethral pressure, preventing urine leakage; this was identified back in 1988 by DeLancey. Miller et al (1998) named the counter-balancing pelvic floor muscle contraction prior to a cough as the 'knack'. Hence pelvic floor strength as well as timing are important considerations. Secondly, the bladder neck receives support from strong, toned pelvic floor muscles (resistant to stretching), thereby limiting its downward movement during effort and exertion, thus preventing urine leakage. Dynamometric studies have shown that women with SUI or mixed urinary incontinence (MUI) demonstrate less pelvic floor muscle tone, maximal strength, rapidity of contraction and endurance as compared to continent women. (Dumoulin 2014)

Thus, there is a growing body of evidence to support the rationale that PFMT improves pelvic floor muscle tone and that it may facilitate more effective automatic motor unit firing of the PFM, preventing PFM descent during increased intra-abdominal pressure, which in turn prevents urine leakage. Given the above biological rationale, the objective of PFMT for SUI is to improve the timing (of contraction), strength, endurance and stiffness of the pelvic floor muscles. (Dumoulin 2014)

Treatment to include

Physiotherapy treatment for SUI would include the following:

1) Patient education and advice, including explanations of risk and prognostic factors, lifestyle advice and use of anatomical diagrams and models to aid teaching (level 4 evidence).

2) Improving general physical condition. UI risk decreases with moderate physical activity (level 3). A strong relationship exists between the lower back pain and respiratory dysfunction and UI.

3) Improvement in pelvic floor function. Various strategies can be used to achieve this, namely:

- PFMT (level 1).

- Biofeedback (level 4). This is not a therapy in itself but used to aid PFMT and is found to be more effective in combination than PFMT alone. It has value in SUI where patients have insufficient awareness and control and may speed up improvement and aid in motivation.

- Electrical stimulation (ES). There is insufficient evidence that ES alone are effective (level 1) and ES in addition to PFMT offers no benefit (level 1); however, it may assist in providing awareness and assist in accuracy but research is lacking.

- Vaginal cones (VC). VC effectiveness compared with no treatment or combined PFMT and ES remain unclear (level 1). Combining PFMT and VC in accordance to strength training principles may be effective (level 3). Many women find VC training difficult and uncomfortable (level 1)

A key component in the success of all treatment is the assessment or diagnostic process. It is used to formulate a specific treatment plan, to identify the nature of the underlying disorder and, more importantly, whether this is modifiable by physiotherapy.

Physiotherapy assessment includes:

- Goal-orientated and systemic history taking including type of incontinence, volume, impact, contributing factors (for example: medication, alcohol, fluid intake, comorbidity). Identify precipitating factors, social impact, effect on hygiene and QOL, measures taken to control UI as well as limiting attitudes and belief systems.

- Physical assessment: this includes inspection of PF at rest, during movement, vaginal/rectal palpating and functional assessment. To evaluate PFM function the following needs to be assessed specific to SUI:

- Voluntary PF contraction – effectiveness of squeeze (absent, weak, normal, strong) coordination, timing, direction, synergistic activity, endurance
- Voluntary relaxation – assess tone, relaxation rated as absent, partial or complete
- Involuntary contraction as with increased IAP-co-contraction, timing, direction, effectiveness.
- Assess abdominal strain (co- activation, scarring, relaxation), lumbar hip and pelvic mobility, dia-

phragm and respiratory components.

- Generalised physical well-being, strength, agility, weight.
- Involuntary movement during straining – relaxation. (Berghmans 2013)

The aim of assessment to ascertain whether the patient has SUI with PFM dysfunction which is modifiable with physiotherapy intervention; and then which parameters require intervention or SUI without PFM dysfunction which will require a referral.

Patient adherence

The greatest challenge in PFMT is patient adherence to treatment. A 2015 randomised controlled trial (RCT) by Berghmans et al looked at strategies to enhance efficacy and adherence to home-based pelvic floor exercises. They included more in-depth patient education and goal-directed behavior, a video with testimonials and reminders; but it did not change patient adherence.

Failure of physiotherapy would drive surgical intervention in mild to moderate SUI; however a 2015 Dutch RCT comparing physiotherapy to surgery in moderate to severe SUI showed that surgery had better outcomes at 1 year but physiotherapy even in moderate to severe SUI had a 53.4% subjective cure and a 64.4% subjective improvement rate. This shows that both physiotherapy and surgery can be offered as first line treatment even in moderate to severe SUI.

After the pleasure of being able to attend a previous international congress and being privileged enough to at-

tend some courses and workshops run by our international peers in well-established academic units, it's with great excitement that I look forward to the 41st meeting of the International Urogynaecological Association (IUGA) in Cape Town in August. We have had a taste of some ideas for workshops and look forward to gaining more experience, especially in the department of physiotherapy patient assessment and palpation skills where we have much to improve on. I strongly encourage you to take advantage of this very rare opportunity to have such a set of skills and talents under one roof. Despite our poor Rand, we are in the pound seats in the academic arena.

Please be aware of early bird registration and please, as physiotherapists, take advantage of the reduced IUGA membership on offer.

Look forward to seeing you all in Cape Town! ✨

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Join us and **MOVE!**

10 May is Movement for Health Day – and South African physiotherapists plan to OWN the day!

After all, we're all about **Movement for Good Health**, aren't we?

We're planning a campaign that will see you and your patients moving together on the day. Keep your eyes peeled on social media for info – go to the Facebook page of the South African Society of Physiotherapy or Twitter handle @PhysioSA and use #MovementForGoodHealth to keep track of the story as it develops!





Upper cervical and upper thoracic manipulation versus mobilization and exercise in patients with cervicogenic headache: a multi-center randomised clinical trial

James R. Dunning et al

BMC Musculoskeletal Disorders 2016

DOI: 10.1186/s12891-016-0912-3

Abstract

Background: Although commonly utilised interventions, no studies have directly compared the effectiveness of cervical and thoracic manipulation to mobilization and exercise in individuals with cervicogenic headache (CH). The purpose of this study was to compare the effects of manipulation to mobilization and exercise in individuals with CH.

Methods: One hundred and ten participants (n=110) with CH were randomized to receive both cervical and thoracic manipulation (n=58) or mobilization and exercise (n=52). The primary outcome was headache intensity as measured by the Numeric Pain Rating Scale (NPRS). Secondary outcomes included headache frequency, headache duration, disability as measured by the Neck Disability Index (NDI), medication intake, and the Global Rating of Change (GRC). The treatment period was 4 weeks with follow-up assessment at 1 week, 4 weeks, and 3 months after initial treatment session. The primary aim was examined with a 2-way mixed-model analysis of variance (ANOVA), with treatment group (manipulation versus mobilization and exercise) as the between subjects variable and time (baseline, 1 week, 4 weeks and 3 months) as the within subjects variable.

Results: The 2X4 ANOVA demonstrated that individuals with CH who received both cervical and thoracic manipulation experienced significantly greater reductions in headache intensity ($p < 0.001$) and disability ($p < 0.001$) than those who received mobilization and exercise at a 3-month follow-up. Individuals in the upper cervical and upper thoracic manipulation group also experienced less frequent headaches and shorter duration of headaches at each follow-up period ($p < 0.001$ for all). Additionally, patient perceived improvement was significantly greater at 1 and 4-week follow-up periods in favour of the manipulation group ($p < 0.001$).

Conclusions: Six to eight sessions of upper cervical and upper thoracic manipulation were shown to be more effective than mobilization and exercise in patients with CH, and the effects were maintained at 3 months.

Treatment of myofascial pain syndrome with lidocaine injection and physical therapy, alone or in combination: a single blind, randomized, controlled clinical trial

Luz Helena Lugo et al

BMC Musculoskeletal Disorders

DOI: 10.1186/s12891-016-0949-3

Abstract

Background: Myofascial pain syndrome (MPS) of the shoulder girdle and cervical region is a common musculoskeletal problem that is often chronic or recurrent. Physical therapy (PT) and lidocaine injections (LI) are two treatments with demonstrated effectiveness compared to a control group, however little is known about their combined value. The objective of this study was to determine whether LI into trigger points combined with a PT program would be more effective than each separate treatment alone in improving pain, function, and quality of life in a group of patients with MPS of the shoulder girdle and cervical region.

Methods: A single-blind, randomized, controlled clinical trial (RCT) was conducted with three parallel groups in the Departments of Physical Medicine and Rehabilitation of two urban hospitals in Medellin, Colombia. One hundred and twenty seven patients with shoulder girdle MPS for more than 6 weeks and pain greater than 40 mm on the visual analogue scale (VAS) were assigned to 1 of 3 intervention groups: PT, LI, or the combination of both (PT+LI). The primary outcome was VAS pain rating at 1-month post-treatment. The secondary outcomes included VAS pain rating at 3 months, and, at both 1 and 3 months post-treatment: (a) function, evaluated by hand-back manoeuvre and the hand-mouth manoeuvre, (b) quality of life, as measured by sub-scales of the Short Form – 36 (SF-36), and (c) depressive symptoms, as measured by the Patient Health Questionnaire – 9 (PHQ-9). Independent t-tests were used to compare outcomes between groups at 1 month and 3 months post-treatment.

Results: In the per protocol analysis, there were no significant intergroup differences in VAS at 1 month PT+LI, 40.8 [25.3] vs. PT, 37.8 [21.9], $p=0.560$ and vs. LI, 44.2 [24.9], $p=0.545$. There were also no differences between groups on secondary outcomes except that the PT and PT+LI groups had higher right upper limb hand-back manoeuvre scores compared to the LI alone group at both 1 and 3 months ($p=0.013$ and $p=0.016$ respectively).

Conclusions: The results of this RCT showed that no differences in pain ratings were observed between the individual treatments (PT or LI) compared to the combined treatment of PT and LI. In general, no difference in primary or secondary outcomes was observed between treatments.



Validity and reliability of arm abduction angle measured on smartphone: a cross-sectional study

Antonio I. Cuesta-Vargas and Cristina Roldán-Jiménez
BMC Musculoskeletal Disorders
DOI: 10.1186/s12891-016-0957-3

Abstract

Background: Measuring range of movement is important in clinical shoulder assessment. Over the years, different techniques have been used to analyse upper limbs mobility. Smartphone image-based goniometer offers a non-invasive easy-to-use method of measuring arm abduction angle. However, the validity of this method has not been previously established. The purpose of this study was to investigate the validity and reliability of an Internet and image-based app (mROM) regarding arm abduction angle in both healthy subjects and patients suffering from shoulder damage.

Methods: Twenty three subjects with shoulder pathology (14 female, 9 male) and 14 healthy subjects (8 female, 6 male) were examined (37 shoulders). mROM app was

used to measure arm abduction angle. Two examiners measured 37 shoulders on 3 separate occasions over 2 days: 2 measurements on the first day and a third one the following day. Descriptive statistics were calculated for descriptive and anthropometric variables, as well as for the first measure of arm abduction angle by photographs and inertial sensors. Reliability was investigated by intraclass correlation coefficients and p values, and validity by Pearson correlation and P.

Results: Intra-rater and inter-rater reliability were high (intraclass correlation coefficients 0.998 and 0.984 respectively) for the total sample, although, for the healthy group, intrareliability was lower and interreliability was no reliable. Measurements from photographs and inertial sensors were highly correlated (Pearson $r=0.964$) for the total sample. However, it was no significant for the healthy group.

Conclusion: Smartphone photographs are a reliable and valid method to measure arm abduction angle, supporting the use of photography obtained through app for measuring joint ROM. This method provides a convenient and precise tool in assessment of arm motion. ✨



Rolene Schoonraad reports on the Mpumalanga Community Service Welcome to new graduates held on 12 February 2015

Our Community Service Welcome was held in Piet Retief and Secunda on 12 February 2016 with four Community Service and twenty qualified physiotherapists in attendance. Myth busting the McKenzie Method, a two-hour lecture, was presented by Ian Grey.

Community Service Welcome was held on the same day in Nelspruit at Kokopelli's restaurant for the Lowveld

Community Service Physiotherapists. Three Community Service physiotherapists attended along with nine qualified physios.

Goody bags were handed out to the Community Service physios with SASP branded pens and pamphlets, as well as sponsored gifts from HiTech Therapy and Physio Wellness Warehouse. There was also an information bookmark with Comm Serve Buddies contact details. ✨



Left and centre: Getting together in Piet Retief. Right: Meeting new faces in Nelspruit



Zulfah Abrahams of SSISA's Community Health Intervention Programmes (left) and running legend Bruce Fordyce at the 2016 SSISA Wellness and Fitness Convention

All about the SSISA Fitness and Wellness Convention

Ria Sandenbergh tells us what happened at the event at Emperors Palace, Johannesburg 17-19 February 2016

The Sport Group of the SASP was invited by the Sport Science Institute of South Africa (SSISA) to take a stand at the #Fitcon Fitness and Wellness Convention in February 2016. In conjunction with the South Gauteng branch of the SASP an excellent stand was put together. Thank you, Heather Talbot (Chair of South Gauteng) for all your assistance and for giving us all the information related to the event.

The main focus point of the stand was the Sensamove pillow which allows you to see on the screen what movements your pelvis is doing. The rationale behind this is that if you're able to control your pelvic girdle it will result in less rigidity in the lumbar area and thus lessening lower back pain. It was highly entertaining for all to watch how difficult it is to play the games associated with the Sensamove.

Range of delegates

The delegate-demographics was different at this convention than at our regular medical congresses, as there was a big contingency of personal trainers, yoga and Pilates instructors and sport scientists. It was well worth



Springbok Rugby player Jesse Kriel (left) running on the Technogym Sawmill, watched by Tony Payne (Technogym Sales & Marketing Director).

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Above: The stand.

the effort to establish physiotherapy in this arena. Good relationships were built with fellow exhibitors including SASMA who hosted the stand next to us.

The 2016 convention saw the Sports Science Institute of




Above: Phatho Zondi (President of SASMA) and Vusi Masilana (member of the Sport Physio Group) working on the SensaMove pillow.

South Africa partner with Technogym, Futurelife, Medtronics and the South African Institute for Drug Free Sport. It included a pre-convention and two highly focused conference days. While the pre-convention's theme was school sports, talent identification and development, the main conference had tracks focusing on health, wellness, performance, technology and business acumen.

The broad spectrum of topics included the \$50

billion mobile health industry; changing behaviour and enhancing performance; just how powerful adequate, quality sleep is in preventing disease and ensuring we bring our A game when it counts; eSports at the Olympic Games; the effect of holding a mass event like the Olympics in changing the host country's physical activity behaviour and discussions on whether social media can influence positive behaviour change.

Four international experts presented at the convention. Professor Adrian Bauman, world-leading public health researcher from the University of Sydney, Australia, with 30 years' experience in the field, addressed us on several topics – including "Low-hanging fruit: if you could do ONE thing to change physical activity behaviour...". We were also joined by Aaron Coutts, professor in sport and exercise science at the University of Technology, Sydney, Australia and Dr Sean Cumming, Department for Health, University of Bath, UK, who specialises in adolescent health and development. Hailed as a visionary of science, technology, ethics, art, media and culture, Andy Maih, who holds the Chair in Science Communication and Future Media at the University of Salford, Manchester, UK, was another exciting presenter.

(Thanks to Kathleen McQuaide for her press release which formed part of this article.) 

Meerkat Marathon

Of course physios were there, Margaret van den Heever assures us!

On Saturday 23 January 2016 the Vodacom Kimberley Road Runners hosted their first annual Meerkat Marathon in Kimberley. Runners could enter for the 5km, 10m, 21km or 42km events, and a total of 443 runners competed in these categories

The Northern Cape Sports Physio Group volunteered to provide post-race rub-downs; our team consisted of three physiotherapists and a biokineticist. Our main aim in provid-

ing this service was to educate runners on injury prevention, the correct way to manage running injuries and the role physiotherapy and proper rehabilitation can play in keeping them healthy and even helping to boost their performance.

The response was amazing; all four of us were busy from the time we arrived until the last runners finished, and we managed to help ease cramps and treat injuries sustained during the race. We were also able to give advice on good training and recovery techniques, footwear and chronic overuse injuries.

At the end of the day we packed up our beds and tent, grateful that we were able to help a few people realise the importance of looking after their bodies, promote the importance of physiotherapy in sport and even make a few friends along the way. The Meerkat Marathon proved to be a great success and we hope to be part of it again in 2017! 🦋

IFOMPT – the mother of the OMPTG



Benita Olivier tells us what the alphabet soup means!

You may have seen the acronym IFOMPT somewhere before and you may have wondered where it fits into the OMPTG structures. It does not stand for “I fiddle over my punctured tyre” or some other instant messaging abbreviation...

Here’s a bit more information. Each SIG values and promotes the professional development of their specific area of interest. In terms of professional development in OMPTG, IFOMPT plays a big role. The International Federation of Orthopaedic Manipulative Physical Therapists (IFOMPT) – an international organisation – represents groups of Manipulative Physical Therapists globally who have completed stringent postgraduate programmes in neuro-musculoskeletal disorders.

IFOMPT, a subgroup of WCPT, actively endorses improved patient management and evidence based practice via the monitoring of educational standards worldwide. South Africa, together with 21 other countries, is an accredited member organisation (MO) of IFOMPT based on the standard of the two MSc OMT programmes hosted at University of Stellenbosch and University of the Witwatersrand.

The curriculum of the OMT course is also aligned with IFOMPT’s Educational Standards Document. Marica Kok represents OMPTG on IFOMPT as MO delegate. Feel free to visit IFOMPT’s website (www.ifompt.org) for more information and some interesting publications and resources. 🦋

SITUATION VACANT

Donald Gordon Hospital: Dynamic, ambitious, eager-to-learn physiotherapist needed for a rapidly growing neuro rehabilitation and geriatric practice in and around hospital. To start mid-Jan 2016. In-patient, out-patient and home visit work done. Neuro experience preferable. Contact Nicole Duff on nicoleduffrehabilitation@gmail.com

PREMISES

Morningside, Sandton: Small Business Units to Rent. Single to multiple offices to let varying 13-50m² within a relaxed atmosphere. Contact Susan or Kathy on 011 787 7400 or post@nss-sa.co.za for further details.

Norwood/Linksfield: Established Private practice looking for a dynamic, passionate and energetic physio with an interest in sports, rehabilitation and children. Phone Farrell 082 565 7497 or email CVs to chadan@telkomsa.net

OTHER

Patient account administration – capturing of fees, EDI to Funds and following up of outstanding amounts. Benefit from improved cash flow. Focus on your practice and leave the administration to us. Mostly Gauteng area. We have been specialists in medical accounts for more than a decade. Contact Philip Potgieter personally at 083 452 4550 or philip@hpaudit.co.za. Our web address is www.dataspoton.co.za

Letter to the editor

I was delighted to see the wonderful effort that physiotherapists had put into their contribution to MammaMagic. Well done, and keep up the good work!
Claudine Bennett

Online database: The National Health Research Database

From Health-e News, 14 January 2016

The online, searchable portal serves as a repository of health-related past and present research conducted in South Africa.

Developed by the National Department of Health and the Health Systems Trust, the website aims to provide the public with a tool to monitor health research. The database also allows researchers and research committees to map geographic areas in which research is being conducted, and provides a snapshot of current and past research priorities.

The website hopes to assist policy makers, donors and researchers in the allocation of resources and prioritisation of research priorities. The site also provides a checklist of criteria that must be fulfilled in order to conduct research in public sector health facilities and relevant provincial department of health contacts. The public can search for research by project title, reference number, objective, study location, field of study or source of funding. 🦋

Visit the website <http://nhrd.hst.org.za/Home/Index>



Running for rhinos along the Chinese Wall

Our very own Wilna-Mari van Staden will be running the Great Wall of China in May this year. "I officially started training a week before Christmas and did my first 15km race on 7 February," she tells *Hands On*. Her plan was to do her first 21km in March and another in April, so by the time you read this, she'll be well away.

Of the eight-legged team running the Wall in May, the male half will be wearing 10kg rhino suits, in support of Save the Rhino. They explain:

Education is vital in ensuring that rhino horn consumption is eradicated as a practice. To achieve this, awareness of the plight of rhinos is needed, not only in supplier countries, but more importantly, in consumer countries.

For this reason the Running Rhinos will be creating awareness and educating people about the plight of rhinos worldwide. To help achieve this goal we have partnered with the following organisations:

Save the Rhino International, which is a UK registered charity whose vision is for all 5 rhino species to thrive in the wild for future generations. To find out more about their incredible work visit www.savetherhino.org.

Welgevonden Game Reserve Non-Profit Company is an internationally acclaimed game reserve in the Waterberg region, Limpopo province, South Africa. It is a Big 5 game reserve with a substantial rhino population and is actively involved in rhino conservation in the community, nationally and internationally. Visit www.welgevonden.org (official website) for more information.

All funds raised will go directly to rhino conservation through Save the Rhino International. 50% of the funds raised through Save the Rhino will go towards rhino related conservation projects including protection, security and education initiatives on Welgevonden Game Reserve.

Money donated is collected via JustGiving. This guarantees all donations go directly to the cause and to ensure complete transparency.

Visit <https://www.justgiving.com/Running-Rhino-s/> to make a donation.

The team is: Bradley Schroder, CEO of Welgevonden Game Reserve in the Waterberg, a private Big Five conservation game park; Greg Canning, Welgevonden's research coordinator; Panayota Galanaki who provides logistics and marketing to the team and lives on Welgevonden, and Wilna-Mari van Staden, who calls herself "Physiotherapist and mad woman". She adds that the other three team members are all patients of hers: "Physio skills turned running partnership all due to great wine... whoops!"

The four will also be at Comrades after their China feat on 22 May, where Wilna-Mari will be providing physio rather than running with the Running Rhinos. 🦏



Advertorial



STRAPPING TIPS

A sprain of the medial collateral ligament of the elbow joint

A young baseball player was sent to me by his coach. He is a baseball pitcher and in the last few months he had done an excessive amount of throwing as he plays baseball for his school and a club.

He had recently developed medial elbow pain which was worse when he was throwing.

The condition is called "the leaguer's elbow" and is caused by the incorrect throwing action.

The result is a valgus stress of the elbow which leads to stretching of the Medial Collateral Ligament. Once this happens the joint is unstable and further damage can occur. There may be lateral compression and posterior impingement.

The condition was explained to the patient and the coach. If the pitcher became "front-on" too early in the throwing motion, the elbow was at risk therefore his acceleration phase of throwing had to be modified.

The patient was treated with mobilizations and physiotherapy modalities and strapped using a rigid tape Leuko Sportstape Premium 3.8cm and an elastic tape Leukoband S 5cm. The coach was also taught the strapping technique so that the MCL would always be protected.

1. With the elbow in slight flexion and using Leukoband S, place two anchors one above the elbow and one below.
2. Cut three strips of Leuko Sportstape Premium which is measured from the top anchor to the bottom anchor.
3. All 3 strips are "stretched" when put into place in order to stop any valgus movement.
4. Place the first strip over the MCL at an angle – see photo.
5. Place the second strip over the MCL at an angle, crossing at the elbow joint.
6. Place the third strip straight down the MCL.
7. Cover the original anchors with anchors using Leukoband S.
8. Re-test to make sure that the MCL is not stretching. If there is

still some movement, add more strips.

The player is now happily back at his sport. His coach straps his elbow for every game and practice.



Please forward any queries or comments with respect to injuries, techniques or Leuko products to askleuko@bsnmedical.com for advice from Joyce Morton, Honorary Life Member of the South African Society of Physiotherapy. Selected questions will be loaded onto the BSN Medical website www.bsnmedical.co.za for reference purposes. Refer to the Leuko Strapping Guide for basic guidelines. Refer to www.bodysupportdirect.co.za for more information about BSN Medical products.