PhysioSA

For every physio who cares

Vol.32 No.5 August 2018

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SUBSCRIPTIONS
Non- SASP® Members: R600 (local) and R990 (overseas) pa incl VAT (8 issues – included in SASP® membership fee)

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DEADLINES: *PhysioSA (was Hands On)* is published 8 times a year in December/January, February, April, May, June, August, September and October. The advertising deadlines are listed below – late submissions should be cleared by telephone. We cannot guarantee the publication of any late material.

ISSUE	DEADLINE
October	24 August
Dec/Jan 2018/19	26 October

CONTRIBUTIONS
The editor accepts contributions from any author.

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SUBMISSIONS Please send any text in a Word or Word-compatible format, to mandiwrite@icon.co.za. Articles should be no longer than 2000 words, ideally, and no shorter than 300. Please don't send pictures as an integral part of a Word document; send them separately, ideally as a Jpeg file and pictures should be at least 1MB. Attachments should be smaller than 6.5MB per e-mail, zip them if needed or send separate e-mails.

PhysioSA™
For every physio who cares

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Editor's comment

By: Mandi Smallhorne

Taking council

Questions about the HPCSA's priorities

So the epic saga of the HPCSA versus Professor Tim Noakes is finally over – with what is surely a crushing defeat for the Health Professions Council of South Africa, with the appeal committee criticising the Council "for effectively thumb-sucking the claim of a 'duty to protect the public' in appeal. It dismisses the claim as an afterthought, 'a fishing expedition'." (Foodmednet)

It really doesn't matter which side of the fence you're on, whether you accept that Noakes' advice to wean babies onto meat and veg rather than cereal-based foods is not 'unconventional' or dangerous, the process should leave any medical practitioner with a couple of questions.

The first is: was this an appropriate use of the HPCSA's funds (which come from your annual fees, after all)?

The HPCSA has two mandates: to protect the public and to guide and regulate the professions.

If the organisation had succeeded in finding Noakes guilty, I question just how much good it would have done in terms of protecting the public. Professor Noakes is not a practising medical practitioner; would deregistering him have made him and his message go away? (I suspect in the current climate of suspicion about 'Big Medicine' and 'Big Pharma', it might have attracted people rather than pushing them away. And as long as there's a group of nearly one and a half million Banting followers posting pics of their newly svelte bodies on Facebook, I doubt deregistration would deter people desperate to lose weight…)

How much did the whole four-year saga cost the HPCSA? If it was less than R3 million, I'd be surprised.

In fact, I'd love to know how much the Council forks out annually in legal fees. The SASP has, as you'd all know, had a legal encounter with the Veterinary Council and Minister of Agriculture in which support from the HPCSA was notably lacking; Netcare has exchanged legal blows with the body (and won); and Henru Kruger, Chief Operating Officer of the Alliance of South African Independent Practitioners Associations (ASAIPA), tells me that the organisation had to take the HPCSA to the Public Protector at one stage – "That's how far we had to go to get their reaction," he says.

Many past and present members of the SASP National Executive Committee (NEC) will remember times when getting the attention of the HPCSA has been a tough and lengthy job. Professor Sumaya Laher, immediate past president of PsySSA (the Psychology Society of South Africa) says that their HPCSA Board was tasked with designing a new scope of practice for the profession – it's been about two years now "despite continuous engagement with the board," she says – a comment that will be familiar to so many in physiotherapy leadership.

"To be fair, we do understand that they have limited capacity," she says, but given the boards only meet four times a year, it's a rather inefficient process that leads to time-wasting. Both capacity and process would bear a rethink – something that, in the public's interest, might have made better use of the millions spent in legal fees hunting Noakes, perhaps?

Or perhaps they could have used it to up their game in a myriad other ways – to be rapidly responsive to professional bodies, or for cleaning up their data about practitioners, which Kruger says is not in good shape, or getting up to speed with telemedicine, which is being rolled out at present: "The regulator lags behind," says Kruger, noting that damage in this field could already have been done. He says the HPCSA is inactive and ineffective, and is outplayed by the Council for Medical Schemes, which is "much more proactive and more visible than the HPCSA".

How does one set a constructive bomb off underneath a body like the HPCSA, to explode it into action? This is not a job for any single professional body – I believe that all the bodies representing registered practitioners should unite in demanding that the Augean stables get cleaned out once and for all, that plans are implemented to make this a more effective institution, responsive both to the public and to practitioners. It's your money, after all!

Who takes responsibility?

The other question registered practitioners should be asking, I believe, is whether there is any accountability asked of those who trigger these cases. Are you simply allowed to lay a complaint about another medical

professional because you're feeling angry and disgruntled about public statements they've made, and then walk away when the hearing process has wound down these interminable roads to an unsuccessful close?

Consider another case where the final act, Act IV, played out in Australia this year. In this case, the subject of the complaint was no longer practising as a medical scientist. Dr Maryanne Demasi qualified as a research scientist early in the 2000s and worked for around a decade researching rheumatoid arthritis. She then moved into the media, doing a successful programme called Catalyst for the Australian Broadcasting Corporation (Demasi has won Australian awards for her work and was a finalist in an international award, too.).

Professor Tim Noakes

Demasi covered two sticky subjects in the course of her job: statins (you know how strongly cardiologists tend to react to the suggestion that cholesterol should not, perhaps, be the target of treatment) and the possible link between wifi, cellphones and health. She triggered vociferous and often vitriolic criticism for these programmes.

Some two years ago, a complainant who remained anonymous (though I'm told it's easy to guess who it might have been) laid a rather nasty charge against Dr Demasi with the university where she had qualified: she had manipulated (duplicated) images for her PhD thesis, it was claimed. In an article published on 21 June, Dr Demasi's PhD supervisors (who testified at the hearing) note that the result was a lengthy process: 11 months of internal investigation, followed by the convening of an independent panel to examine the allegations, in accordance with the Australian Code for the Responsible Conduct of Research. The process culminated in a four-day hearing; the complainant turned down an invitation to be there and state their case; they also refused the option of sending in a sworn statement.

Dr Demasi was exonerated.

But her case had been reported worldwide. She was referred to as a 'controversial' journalist; much of the reporting showed clear and perhaps slightly gleeful bias against her. (I think it was rather shameful of the highly-regarded watchdog online publication, RetractionWatch, which normally I admire greatly, to headline a report on her exoneration thus: *Controversial Australian science journalist admits to duplication in her PhD thesis*. The opening paragraph then says, "A prominent (yet controversial) journalist in Australia has admitted to duplicating three images that were part of her PhD thesis — a practice outside experts agreed was acceptable, if not ideal, at the time, according to a report released today.")

In a book review on 6 April this year, an IOL writer notes that "the stress of the HPCSA [hearing] had a shattering emotional impact on Noakes: 'The results of my personal choice would prove to be brutal for myself, my wife, and the rest of our family, beyond anything I could possibly have imagined'…". The toll on Dr Demasi was also great – she speaks in measured terms of suffering from "chronic stress' during the long drawn-out process. And both of them have suffered financially, to a lesser or greater extent – Noakes was lucky to have lawyers who acted pro bono, but the impact on Demasi's career is at this point incalculable.

Should there not be some sort of accountability built into this process? Both Demasi and Noakes are public figures, and of course one does not want to place obstacles in the way of whistleblowers with real concerns. But there is good reason to suspect, in these cases, that there's an element of 'trumping up' here – that disgruntled people set out to 'bring down' or 'teach a lesson to' their targets.

Of course, the two of them (and a number of others who've been affected by similar cases) could go to law for satisfaction. But that costs money and even more time and stress. Is this not something that should be handled at the level of regulators and professional bodies? I'm not sure how to manage it – perhaps if the exonerated party expresses a wish to have the circumstances investigated, regulations should require that an independent body looks into how and why the complaint was laid, and perhaps imposes some sanction on the complainant, should he or she be found to have acted from some sort of malice rather than pure concern for the public good. Perhaps just knowing that this possibility exists would prevent frivolous charges, or ones laid out of personal animus against the target.

I'd be interested to hear your thoughts on mandiwrite@icon.co.za.

This is an opinion piece; it expresses Mandi Smallhorne's personal opinion and does not reflect the views of the SASP.

Cutting edge New findings provide interesting insights

Air pollution contributes significantly to diabetes globally

New research links outdoor air pollution – even at levels deemed safe – to an increased risk of diabetes globally, according to a study from Washington University School of Medicine in St. Louis and the Veterans Affairs (VA) St. Louis Health Care System.

The findings raise the possibility that reducing pollution may lead to a drop in diabetes cases in heavily polluted countries such as India and less polluted ones such as the United States.

"Our research shows a significant link between air pollution and diabetes globally," said Ziyad Al-Aly, MD, the study's senior author and an assistant professor of medicine at Washington University. "We found an increased risk, even at low levels of air pollution currently considered safe by the U.S. Environmental Protection Agency (EPA) and the World Health Organization (WHO). This is important because many industry lobbying groups argue that current levels are too stringent and should be relaxed. Evidence shows that current levels are still not sufficiently safe and need to be tightened."

The findings were published June 29 in The Lancet Planetary Health.

While growing evidence has suggested a link between air pollution and diabetes, researchers have not attempted to quantify that burden until now.

To evaluate outdoor air pollution, the researchers looked at particulate matter, airborne microscopic pieces of dust, dirt, smoke, soot and liquid droplets. Previous studies have found that such particles can enter the lungs and invade the bloodstream, contributing to major health conditions such as heart disease, stroke, cancer and kidney disease. In diabetes, pollution is thought to reduce insulin production and trigger inflammation, preventing the body from converting blood glucose into energy.

Overall, the researchers estimated that pollution contributed to 3.2 million new diabetes cases globally in 2016, which represents about 14 percent of all new diabetes cases globally that year. They also estimated that 8.2 million years of healthy life were lost in 2016 due to pollution-linked diabetes, representing about 14 percent of all years of healthy life lost due to diabetes from any cause.

In the United States, the study attributed 150,000 new cases of diabetes per year to air pollution and 350,000 years of healthy life lost annually.

The Washington University team, in collaboration with scientists at the Veterans Affairs' Clinical Epidemiology Center, examined the relationship between particulate matter and the risk of diabetes by first analyzing data from 1.7 million U.S. veterans who were followed for a median of 8.5 years. The veterans did not have histories of diabetes. The researchers linked that patient data with the EPA's land-based air monitoring systems as well as space-borne satellites operated by the National Aeronautics and Space Administration (NASA). They used several statistical models and tested the validity against controls such as ambient air sodium concentrations, which have no link to diabetes, and lower limb fractures, which have no link to outdoor air pollution, as well as the risk of developing diabetes, which exhibited a strong link to air pollution. This exercise helped the researchers weed out spurious associations.

Then, they sifted through all research related to diabetes and outdoor air pollution and devised a model to evaluate diabetes risk across various pollution levels.

Finally, they analyzed data from the Global Burden of Disease study [...] to estimate annual cases of diabetes and healthy years of life lost due to pollution.

The researchers also found that the overall risk of pollution-related diabetes is tilted more toward lower-income countries such as India that lack the resources for environmental mitigation systems and clean-air policies. For instance, poverty-stricken countries facing a higher diabetes-pollution risk include Afghanistan, Papua New Guinea and Guyana, while richer countries such as France, Finland and Iceland experience a lower risk. The U.S. experiences a moderate risk of pollution-related diabetes.

In the U.S., the EPA's pollution threshold is 12 micrograms per cubic meter of air, the highest level of air pollution considered safe for the public, as set by the Clean Air Act of 1990 and updated in 2012. However, using mathematical models, Al-Aly's team established an increased diabetes risk at 2.4 micrograms per cubic meter of air. Based on VA data, among a sample of veterans exposed to pollution at a level of between 5 to 10 micrograms per cubic meter of air, about 21 percent developed diabetes. When that exposure increases to 11.9 to 13.6 micrograms per cubic meter of air, about 24 percent of the group developed diabetes. A 3 percent difference appears small, but it represents an increase of 5,000 to 6,000 new diabetes cases per 100,000 people in a given year.

In October 2017, The Lancet Commission on pollution and health published a report outlining knowledge gaps on pollution's harmful health effects. One of its recommendations was to define and quantify the relationship between pollution and diabetes.

Reference

Bowe B, Xie Y, Li T, Yan Y, Xian H, Al-Aly Z. The 2016 Global and National Burden of Diabetes Mellitus Attributable to Fine Particulate Matter Air Pollution. The Lancet Planetary Health, June 29, 2018

Reaching across sectors

Professional Liaison Consultant Magda Fourie explains how the SASP's Universal Health Coverage – Physiotherapy Project will meet its eighth goal

GOAL 8: Assistive Devices

This is the last goal envisaged in the Framework and Strategy for Disability and Rehabilitation services (FSDR) document published by the National Department of Health (NDOH) and therefore the end of this series of articles. You are once more invited to send your thoughts, suggestions and comments to Magda Fourie at profliaison.consultant@saphysio.co.za.

Goal 8:

The FSDR document explains goal 8 as: "*Improve access to appropriate assistive/technology and accessories*".

In comparison, the Private Practice Management Accreditation programme does not deal with assistive devices (ADs) per se, but prescribing of ADs will form part of Standard 5 pertaining to the quality of your evaluation, diagnosis and treatment plan. This section aims to: "*….. institute quality management principles, which monitor the quality of service delivery and continually review and improve service delivery.*"

Objectives of this goal in the FSDR document

One objective has been identified within this goal:

1. **Provide and revise guidelines on provision of Assistive Devices (ADs) and accessories**

   The targets were as follows:

- To develop a guideline on provision of appropriate ADs and accessories by March 2017
- To revise the guidelines mentioned above in 10 NHI districts by March 2018
- To revise the guidelines mentioned above in 26 districts by March 2019
- To revise the guidelines mentioned above in all districts by March 2020.

What needs to be done by the SASP and the physiotherapy community to comply with the objectives of goal 8 mentioned in the FSDR document?

1. **National Department of Health tender for Assistive Devices**

   Rehabilitation personnel must be included in all tenders pertaining to Assistive Devices (ADs) as we form an integral part of the team deciding who should be issued with which device.

   These tenders are revised from time to time to determine and include new technology, what is appropriate and which device is in the best interest of the patient. Costing is obviously important and needs to be considered. It would be beneficial for South Africa to benchmark existing guidelines for the provision of ADs and accessories with that of the World Health Organisation (WHO).

   Physiotherapists must insist on and motivate for the best and most appropriate ADs, as the cheapest device is not necessarily of the best quality. An example can be given of cheaper wheelchairs not suitable for the rough terrain where patients often need to use their wheelchairs, resulting in the chairs breaking easily and needing to be repaired or replaced often.

2. **Procurement of Assistive Devices**

   Most of the provinces struggle with the ordering, procurement and management of devices. This results in patients being discharged from hospital without the appropriate AD. Accessibility to health services includes access to ADs as per the National Health Act. It is of the utmost importance to also have a maintenance plan for ADs within the facility, district and province, providing quick repair services for patients. On the flip side, patients must be made aware of their responsibility to look after the ADs given to them.

3. **Data collection**

   The data elements collected for the NDOH at the moment are not sufficient. Currently the Disability and Rehabilitation services are only measured according to "the number of new wheelchairs issued". Understandably this data information provides nothing meaningful about the number of patients seen, the type of patients seen, other ADs provided such as hearing aids, glasses and the like.

   A starting point might be to use ICD-10 coding to first determine the burden of disease in a province. Once the data of the conditions seen by physiotherapists have been analysed, it would be easier to determine which ADs would be required for these conditions. This system will allow electronic monitoring of ADs per facility, per district and eventually per province in South Africa.

Who needs to be involved?

- Managers responsible for the procurement systems within all provinces
- Companies providing ADs
- Public sector physiotherapy services
- Private sector physiotherapy practice owners
- Professional Liaison Consultant.

Wendy Holliday demonstrating on Willie Fourie during the Bike Fitting workshop

All about movement

Ria Sandenbergh reports on a well-received congress

The inaugural MOVE | SCIENCE | REHAB Congress was held at the Saint Georges Hotel in Irene from 25-27 May 2018. 10 exhibitors, 20 lecturers and 15 students joined an enthusiastic mix of physios and biokineticists. The congress was held over three days incorporating clinical lectures, short workshops and full-day courses. Professor Christa Jansen van Rensburg presented the opening address, followed by Dr Nicol van Dyk and Gareth Walton as keynote speakers. Antonio Robustelli from Italy completed the list of international speakers.

The focus of the congress was everything about movement – the science of biomechanics, prevention as well as rehabilitation of injuries. It was also about networking and learning from each other. The ethics presentation on social media presented by Dr van Dyk was thought provoking – it made me think twice when I reach for my phone…

Dr Gerhard Vosloo and Megyn Robertson presented an interesting talk on concussion and the rehabilitation thereof. Dr Hannes Jonker and rehabilitation team

Above: Brent Grimsley, Nicol van Dyk and Arnold Vlok
Right: Gareth Walton, Nicol van Dyk, Ria Sandenbergh, Carine van der Merwe, Lau Mare Naude, Claudette Cornelissen, Antonio Robustelli, Elaine Burger, Brent Grimsley.

members presented on surgery and rehabilitation of the knee and shoulder. Elaine Burger handled the physiotherapy section of this presentation.

On Sunday each delegate could attend his or her choice of a full-day course: Hamstring Rehabilitation, Tendon Rehab, Exercise is Medicine, MAP or Building Speed. The 'athletes' attending the Building Speed course found a few muscles they were previously unaware of, while the MAP class was much suppler after a day of mobilisation. Arnold Vlok presented on tendon rehabilitation and optimal loading of these structures. Dr Nicol van Dyk presented on hamstring rehabilitation, according to the Aspetar Hamstring Rehabilitation Protocol. The Exercise is Medicine accreditation course was presented by Dr Georgia Torres.

The new General Executive Council of the Sport Physio Group was elected; congratulations to Elaine Burger who was elected as the new chairman, with Claudette Smit as treasurer and Lou-Mare Naude as secretary and PR. www.movesciencerehab.co.za.

Above left: Brent Grimsley, right, Nicol van Dyk.
Top: Participants joined in for Gareth Walton's Build Speed Course practical.
Centre: Gareth Walton demonstrates an exercise.

Ready, steady, think!

Improving physiotherapy access enhancing wellness

SASP CONGRESS 14-16 SEPTEMBER 2018

There'll be so much to think about at the SASP Congress, to be held from 14-16 September 2018. We whet your appetite with excerpts from the thought-provoking abstracts.

THE SPEAKERS

Dr Emma Stokes, President of the World Confederation of Physical Therapy

Dr Stokes will provide an inspirational kick-off with a keynote speech on Global Physiotherapy: A Community Better Together.

Dr Jeremy Lewis

The elephant in the room: the medicalisation of normality in musculoskeletal practice

Historically, musculoskeletal practice focused on addressing traumatic events, primarily fractures and dislocations. Although the management of trauma continues as an essential component of musculoskeletal conditions, musculoskeletal management has evolved and much of the focus is now centred on the management of non-traumatic presentations, most commonly associated with pain. Hypotheses have been presented to explain the pathoaetiology and management of these presentations. Many of them relate to 'abnormalities' of posture where deviations from an idealised norm is the basis for the presenting symptoms. Examples include; forward head posture and its association with headaches, neck and shoulder pain, lumbopelvic postural abnormalities and low back pain, deviations from subtalar neutral and foot pain. Other examples include an assumption that identified non-traumatic structural abnormalities, such as; rotator cuff tears, acromial spurs, medial meniscal tears, and many other presentations typically identified using a variety of imaging formats are the cause of symptoms, and surgery to 'restore' normal structure is required to reduce the pain and improve function.

Many of the techniques to restore 'normality' have been shown to be placebo procedures and outcomes may relate to the enforced post-surgical relative rest on the tissues and the ensuing graduated rehabilitation. Additionally, outcomes in some presentations may be more dependent on psychosocial factors than physical factors.

This lecture will address a number of these areas of uncertainty and will highlight areas of uncertainty in current musculoskeletal practice. Suggestions for how the musculoskeletal community may considering moving forward will also be discussed.

Dr Ina Diener

Is manual therapy for musculoskeletal dysfunction a dying art in our profession?

Manual therapy is currently much under discussion by physiotherapists at congresses and on social media. This presentation aims to discuss the current evidence for the use of manual therapy in musculoskeletal pain conditions, and will be suggesting the role of orthopaedic manual therapists in an evidence-based approach to musculoskeletal pain.

Presentations at the last IFOMPT congress where this was extensively discussed and abundant research in the field will be reviewed.

The collective opinion, based on the outcome of research in the last ten years, is that the local effect of manual therapy is less than always proposed, and that the neurophysiological effect of joint movement plays a meaningful role in successful outcomes. Other strong

outcomes of research was established where manual therapy was used in conjunction with exercise and pain education.

OMT has a local as well as distant neurophysiological effect. OMT, as other therapies, should be delivered in a biopsychosocial paradigm, where a therapeutic alliance and effective clinical communication are the cornerstones of the intervention. OMT should be part of a package of care, which should also include therapeutic exercise and pain neuroscience education. The end-result of OMT intervention should be for a patient to get back to their preferred function and participation. OMT is therefore not a dying art, but has evolved beyond only targeting structures. OMT therefore, should form a meaningful part of a package of care in musculoskeletal pain conditions.

It is the ethical responsibility of physiotherapists to maintain their knowledge and skill in the field they are working. Healthcare costs are escalating and more professions enter the field of musculoskeletal care. Physiotherapists must practice and promote the best evidence-based care to maintain their important position in the healthcare team.

Dr Corlia Brandt

Management of women with pelvic floor dysfunction: development of a neuro-musculoskeletal approach

The pelvic floor muscles (PFM) are important in the prevention and treatment of pelvic floor dysfunction (PFD). Controversy and a lack of research exist regarding the interaction between the PFM and abdominal muscles (motor control), biopsychosocial aspects, effective rehabilitation, and pelvic floor dysfunction. An integrated investigation into PFD was indicated, based on neuro-musculoskeletal models.

The study aimed to determine the effect on/interaction among quality of life (QOL), PFM, and abdominal muscle function in women with PFD.

81 Women with PFD were randomised to three groups in a double-blind RCT. Data indicated socio-economic, lifestyle and emotional impairment, as well as abdominal

and PFM dysfunction (n=100). PFM training yielded significant changes in the levator hiatus (Valsalva) (-3.5mm, 95% CI [-10.3;-1.8]), thickness of the perineal body (1.5mm, 95% CI [0.5;4.1]), and PFM endurance (2sec, 95% CI [1;5]) during the first three months. Group 2 had significant changes in abdominal muscle function (Sahrmann and PBU levels, 95% CIs [1;3] and [1;9]), and QOL (95% CI [1.5;28.4]) in addition to improved PFM function up to six months. No statistically significant differences were found in the magnitude of the changes among the groups. Significant correlations were found between different muscle variables ($r>0.4$, $p<0.001$).

Social/emotional aspects, co-morbidities, PFM and abdominal muscle function may affect the neuro-musculoskeletal interaction and biomechanics necessary for effective prevention and treatment of PFD.

Co-morbidities, associated symptoms and signs of PFD, and the effect they may have on motor control and QOL, motivates for a comprehensive, patient-specific, lifestyle orientated, and biopsychosocial rehabilitation model for patients with PFD.

Anita Erens

Are we as physiotherapists able to be part of the medico-legal team?

When there is some form of personal legal claim such as where a person has incurred an injury in a road accident, suffered damages and has a civil claim, had an injury on duty or has been the victim of medical negligence and their ability to move has been affected whether in the short or long term, a physiotherapist should be consulted to give expert evidence in the claim. However, this is not happening as frequently as should be and it is being left up to other professions to make recommendations regarding the physical rehabilitation. Physiotherapists often feel unskilled in how to provide the necessary information for the legal team or they provide it, not appreciating the pitfalls they can encounter.

If we as a profession want to ensure that persons incurring mobility dysfunctions because of one of the aforementioned reasons, are adequately compensated so they can make use of our services to achieve full rehabilitation, then it is our task as a profession to address this issue. We need to train ourselves to be able to provide the essential information to meet and assist the requirements of the legal claim.

The aim of the talk will be to give a general overview of the legal process focusing on when and how physiotherapists can be consulted. It will identify skills needed and suggest possible ways of developing them so that they can become an integral part of the medico-legal team.

Eleonora Lozano

Burn care: a review of recommendations and practice guidelines for physiotherapists

The talk on ISBI practice guidelines for burns aims to discuss the practice guidelines (PGs) for burn care established by the 2014-2016 International Society of Burn Injury (ISBI) committee to improve care of burn patient in both resource-limited settings (RLs) and resource-abundant settings. An important component of this effort is to communicate a consensus opinion on recommendations for burn care for different aspects of burn management. An additional goal is to reduce costs by outlining effective and efficient recommendations for management of medical problems specific to burn care. These recommendations are supported by the best research evidence, as well as by expert opinion. Although the ISBI vision was the creation of clinical guidelines that could be applicable in RLS, the ISBI PGs for Burn Care have been written to address the needs of burn specialists everywhere in the world.

Included in the talk on Clinical practice recommendations for positioning of the burn patient, is a review of the recommendations for positioning patients with acute burn. Review of the literature revealed minimal evidence- based practice regarding the positioning of burn patients in the acute and intermediate phases of recovery. These positioning recommendations are designed to guide those rehabilitation professionals who treat burn survivors during their acute hospitalization and are intended to assist in the understanding and development of effective positioning regimens.

The popularity of video game use in burns rehabilitation has grown because, in addition to facilitating maintenance of range of motion (ROM), the virtual imaging characteristics of these games provide distraction from pain. The Paediatric Burns Unit (PBU) at Chris Hani Baragwanath Academic Hospital (CHBAH) received a Microsoft Xbox 360 Kinect™ as an adjunct to be used for therapy and rehabilitation. This study aimed to investigate the effect of using the Xbox Kinect™ on outcomes of children in the PBU at CHBAH. The use of the Xbox Kinect™ used in this study has been shown to be a beneficial and useful adjunct to burns rehabilitation in this paediatric burns population. Currently, there is limited information and research into interventions for children with burns in South Africa. The addition of Xbox Kinect™ to standard physiotherapy in-patient care, at this facility, was both enjoyable and effective and should be considered where funding is available.

Professor Brenda Morrow

Current Perspectives In Managing Children With Respiratory Muscle Weakness

Neuromuscular disorders (NMD) in childhood may be acute or chronic, congenital or acquired, and affecting different targets in the neuromuscular pathway. In severe cases, respiratory muscle weakness occurs, impacting on cough efficacy and ultimately resulting in chronic pulmonary insufficiency and recurrent chest infections, which predispose to morbidity and mortality. Optimising pulmonary function and cough clearance are among the main aims of physiotherapy management in children with NMD and respiratory muscle weakness.

This talk aims to provide an overview of paediatric NMD, including pathophysiology and impact on the respiratory system. The role of respiratory muscle training, to preserve or improve respiratory muscle strength, in NMD will be discussed, presenting evidence from South African clinical studies; as well as an overview of cough augmentation modalities, as per the recommendations of the 228th European Neuromuscular Confederation's International Workshop on Airway Clearance Techniques in Neuromuscular Disorders, held in the Netherlands in 2017 (the presenter is a member of this Confederation). These modalities include those aimed at supporting the inspiratory component of the cough (e.g. manual insufflation/bagging, breath stacking and glossopharyngeal breathing); augmenting expiratory cough flow (e.g. manually assisted cough); and supporting both inspiration and expiratory flow (e.g. mechanical insufflation-exsufflation). The role of "peripheral" vs. "proximal" airway clearance techniques will further be explored and explained in the context of respiratory muscle weakness in NMD.

From a survey undertaken amongst South African physiotherapists, it appears that there is limited exposure and experience in managing paediatric and adolescent patients with NMD. Current cardiopulmonary physiotherapy management of children with NMD in South Africa is generally suboptimal and not aligned with international standards. Urgent attention needs to be placed on the role of physiotherapy in preventing or minimizing the respiratory complications of NMD in order to improve the quality of life of children living with NMD in South Africa.

This talk aims to provide an overview of paediatric NMD, including pathophysiology and impact on the respiratory system.

Dr Veronica Ntsiea

Stroke Rehabilitation In South Africa

Stroke survivors face many challenges such as having no dedicated beds, early discharge due to pressure on bed numbers, too few neurological rehabilitation centres and limited therapy at community level. In stroke rehabilitation, the goal is to discharge patients at their optimal functional independent level. Sometimes patients are sent home without rehabilitation and they receive no intervention once they are at home. Thus, carers need to be involved actively with rehabilitation and receive training from therapists to assist from an early stage with mobility, transfers, and activities of daily living. Successful rehabilitation outcomes depend on the effectiveness of treatment and the extent to which a patient complies with the treatment regime.

Stroke rehabilitation and research includes the following: prevention and management of risk factors; acute, subacute and chronic stage management of stroke survivors; determination of functional outcomes at admission, discharge and post discharge; Caregiver and stroke survivors' knowledge, strain, quality of life, and perceptions; Community reintegration (including return to work).

Literature that covers all South African based stroke rehabilitation research will be presented. The aim is to work towards a more centralised approach towards stroke management in South Africa and possibly Africa at large.

Greg Lynch

Are you sure you have cleared the Spine?

It is well established that the Cervical, Thoracic or Lumbar spine can cause somatic referred pain into the extremities. Commonly, this extremity pain is accompanied by spinal pain and the relationship between the two is clear enough to make it obvious both to the patient and to the healthcare professional that the source of the problem is indeed spinal. It has been reported in the literature and it is common clinical experience among practitioners that extremity pain of spinal origin can also present as isolated pain with no obviously accompanying spinal pain. In these cases, the patient may interpret the pain as coming from the extremity and without an adequate differentiation process the healthcare professional may also make this interpretation. This can lead to wasted time and resources and suboptimal outcomes, as the intervention is not applied to where the source of the problem lies. .

Women's bodies, women's selves

In women's month, the limelight falls on the Women's Health Physiotherapy Group in an article by Hester van Aswegen

Can you remember when the Women's Health Physiotherapy Group (WHPG) was still known as the Obstetric Association of South Africa?

Originally this group was formed in the early seventies for those physiotherapists working in the ante- and postnatal fields. More than twenty years on, in 1996, the group changed its name to The Association for Women's Health of the Society of Physiotherapy. The idea was to incorporate all the areas involved with women' health, not justy the ante- and postnatal fields, but also management of incontinence and pelvic organ prolapse. Currently our group is known as WHPG – Women's Health Physiotherapy Group.

In the last couple of years the field of interest has grown by leaps and bounds to incorporate all pelvic floor dysfunction, such as anorectal problems, pelvic pain, and men's and children's related pelvic problems. Women's health conditions are still a major part of our management rationale; this includes patients with lymphoedema after mastectomies or other cancer-related treatment, and the rehabilitation of postnatal patients with a diastasis recti or pelvic floor problem. Because of this broadening of the range, another name change is on the cards: the International Organisation of Physical Therapists in Women's Health (IOPTWH) is in the process of looking at a possible name change to try and incorporate all of the above into a more comprehensive name.

Wide range of patients

I am sure that most physiotherapists are aware that you can refer patients with incontinence and prolapse to a Women's Health physio, but do you know that we can also treat patients with female sexual dysfunction, men with erectile dysfunction, and patients with constipation and haemorrhoids?

One of the most important things to evaluate is whether a patient has a hypotonic (thus loose, lax) pelvic floor or a hypertonic (tight) pelvic floor. This will make a difference in your prescription of exercises and your approach to the treatment of each patient. Most patients do not need 100 Kegel's a day, and unfortunately that is still often prescribed. But if a detailed examination has been performed by a therapist trained in the field of pelvic health a lot of confusion and unhappiness can be avoided because patients are not experiencing results.

Star turns

Recent Achievements of WHPG members

Two Cape Town physiotherapists received Honorary Life Membership of the WHPG in 2017 for their contributions to and support of WHPG since the late 1990s. Thank you, Lindsay Wallace and Ruth Katzman for many hours of hard work in promoting Women's Health Physiotherapy in South Africa.

Karen Swanepoel, a Bloemfontein based physiotherapist has been very busy writing several articles for magazines in order to educate the public about physiotherapy.

She completed her BSc Physiotherapy Degree in 2002 at the University of the Free State. She works in the field of women's health physiotherapy and musculo-skeletal conditions. She enjoys blogging on her website www.regain.co.za and can be contacted at info@regain.co.za or swanepoelkaren@gmail.com

Articles were published in the *Milestones Magazine* (Childhood Constipation) and the *Baby and Beyond Magazine* (Baby Proof your Body – pregnancy exercise) and another on Potty Training Advice has been submitted (*Milestones Magazine*) for publication in the third term. We believe that patients will refer themselves if they understand our value.

Karen Swanepoel teaching Module 4 in Cape Town in March 2018

Karen also compiled a booklet on bladder education for women's health patients to assist women's health physiotherapists to give their patients the info in an easy to read format. It is called "Female bladder problems and Physiotherapy" and has been well received by both colleagues and patients alike. Physiotherapists can contact Karen Swanepoel at info@regain.co.za for more details.

Plans to develop clinics in public hospitals

WHPG is continually trying to improve the way we teach on various topics. As internal pelvic floor examination is a completely new technique taught to postgraduate physiotherapists, there is a huge need to find ways of helping physiotherapists who have completed the basic modules to practise their newly learnt skills. It is difficult to obtain the necessary exposure to patients in a private practice setting and so we have been trying to set up clinics at public sector hospitals where participants can gain experience by working with a physiotherapist qualified in the field. In Cape Town such a clinic was established at Tygerberg hospital. Lonese Jacobs gives us an overview:

Tygerberg hospital is the largest hospital in the Western Cape and the second largest hospital in the country. It is a teaching hospital working with the University of Stellenbosch's Health Science Facility. A service offered by Tygerberg Hospital is an out-patient urogynaecology clinic. The team working in this clinic includes urogynaecologists, gynaecologists, urologists and colo-rectal surgeons to name a few. Women's health physiotherapy is a part of this team, offering pelvic floor rehab and treatment of pelvic floor dysfunctions.

At the onset of the service being offered, the patients were only referred after the urogynaecologist had done a full evaluation. This has since changed. An increasing number of referrals are received from gynaecology, urology and paediatric departments. There is no waiting list for physiotherapy, patients are accommodated on the soonest date that they can attend. As awareness of the service spreads, so the number of referrals rises. The types of patients seen varies from hypotonic pelvic floor

Learning curve

WHPG Courses

WHPG runs several courses and workshops each year on different topics. We also run evening lectures on interesting topics and are planning to introduce courses and workshops on an e-learning platform to make it more accessible to obtain CPD points.

The various WHP modules are presented in different provinces over a two- to three-year cycle. There are two basic pelvic floor modules where assessment and treatment of pelvic floor dysfunctions are introduced and internal vaginal examination of the pelvic floor is taught. (Module 1 - Essential concepts and the hypotonic pelvic floor and module 2 - Exploring the hypertonic pelvic floor and refining skills). Then there is a module on the childbearing year to complete your knowledge of ante-and postnatal assessment and treatment.

WHP Module 1 and WHP module 2 were run this year in Gauteng and KZN respectively. The aim is to present these modules in different provinces each year. After completion of these modules a physiotherapist is equipped with the basic skills to assess and treat pelvic dysfunction. *It is important to remember that you have to attend these courses to qualify to examine the pelvic floor muscles internally, as you will not be covered by malpractice insurance otherwise.*

The anorectal module will be presented in 2019 for the first time as a three-day module. We are also

COURSE CALENDAR

The following courses will be run during the rest of 2018. ***Please note the date of the AGM***

1 Sept 2018	PFM practical workshop using EMG and real-time ultrasound	Corina Avni	Hester van Aswegen hesterva@abSouth Africamail.co.za	Gauteng
22 Aug 2018	Gauteng WHPG AGM – get CPD points for free! Lecture: Hot flushes, hormones and your lady bits!	Dr Jireh Serfontein	Hester van Aswegen hesterva@absamail.co.za	Kloof Hospital Pretoria
Sept 2018	South AfricaSP symposium - lecture By Dr Corlia Brandt on corlia.brandt@wits.ac.za	Corlia Brandt		
Oct 2018	Vaginal laser therapy – how can this help your patient? Evening lecture	Dr Apostolates	Hester van Aswegen hesterva@ absamail.co.za	Rand-burg, Gauteng
19-21 Oct 2018	WHP mod 2 Pelvic floor	Bettina Moser Hester van Aswegen		

to chronic pelvic pain. The physiotherapists are a valued part of the team.

One of the requirements of employment within this clinic as a women's health physiotherapist is research. The physiotherapists are supported academically by Stellenbosch University and clinically by the Obstetrics and Gynaecology department.

The physiotherapists are employed on a sessional basis, four hours a week. We are available for bookings on Tuesday afternoon if anyone would like to visit. The physiotherapy division of the clinic has its own schedule. It includes a set of four classes to be attended and individual sessions. The classes include information sessions about women's health-related topics, pelvic floor rehabilitation exercises and a support group. The support group offers women the opportunity to realise they are not alone with their struggles with these very personal, and often embarrassing problems, or the frustrations that come with suffering from them. Women are encouraged to share the knowledge gained at the clinic with women in their communities to help spread awareness of women's health.

The types of conditions treated by the physiotherapists at this clinic include:

- Urinary incontinence
- Urinary urgency/ frequency/overactive bladder syndrome
- Pelvic organ prolapses
- Painful bladder syndrome
- Faecal incontinence
- Dyspareunia
- Vulvodynia
- Pelvic pain

The patients and health professionals express enormous appreciation of the physiotherapists and their expertise. You'll often hear patients say they wish they had known about the services offered by the clinic sooner. It is our hope that the women who walk away

updating our Healthy Aging Module which covers osteoporosis and menopause.

Feedback

The Pregnancy Module 4 was presented in Cape Town in February 2018 with around fifteen attending. Participants were instructed on all aspects of a normal pregnancy, all complications of pregnancy, exercise in pregnancy, antenatal treatments as well as the post-natal management in hospital. The exercise class was well received. The breastfeeding practical on the third afternoon was of especial value as Annelie Bonthuys demonstrated valuable latching techniques; she also arranged to have a twin mom come in to show us tandem feeding. WHPG Western Cape received generous sponsorship from one of the suppliers, Hitech Therapy, which sponsored handouts and gave a demonstration on some of the newest machines available in the women's health field.

Because of Dr Ina Diener' efforts, the first ever Men's Health Course was presented in South Africa just before the World Conference for Physical Therapy (WCPT) in July 2017. Two international lecturers – Joanne Milios (from Australia) and Gerard Greene (from UK) – entertained a group of 32 physiotherapists (including eight male physiotherapists) at the beautiful venue of the Stellenbosch Sport academy.

Gerard and Joanne shared their wealth of knowledge to cover basic male anatomy and pathology, male pelvic pain, post prostatectomy patients and the assessment and treatment thereof.

We hope to build on this and arrange similar courses in South Africa soon.

Men's Health Course, June 2017

Venue: Stellenbosch Academy of Sport

Left to Right, Hester van Aswegen, Gerard Greene, Celeste Andrea and Joanne Milios.

Lonese Jacobs (centre, in pink) taught Module 1 to an enthusiastic group in Johannesburg

from their experience with the urogyneacology clinic, and specifically physiotherapy, share their stories and encourage more women to seek help for their pelvic floor dysfunction.

As part of the holistic management of a patient, we often refer patients on to other physiotherapists for general physiotherapy of other musculoskeletal conditions. Other referrals include the social worker, as some of the women might be dealing with social issues which fall outside our scope of practice.

The predominant reason reported for poor adherence has been financial (lack of money to travel to the hospital) and work commitments/restriction (unable to get the time off to attend physiotherapy with a difficult employer or the impact of no-work-no-pay). In these situations, we work with the patient to find dates that suit them and help them adhere to the schedule.

We were immensely proud to be selected as a site visit for the WCPT held in Cape Town 2017. Attendees (physiotherapists) from around the world expressed their wish to implement similar multi-disciplinary, focused urogynecological clinics in their respective countries.

Thank you to the team at Tygerberg hospital, the urogynaecology team, for working so hard to ensure we have a place in your clinic. Thank you to the physiotherapists who have spent time at the clinic with me; I have been in the clinic five years and counting. And a big thank you to the Women's Health Special Interest Group for the support in my journey as a physiotherapist with a special interest in women's health. I hope this will inspire any physiotherapist who have the same passion to find a hospital or clinic and offer your time to help make the lives of women more enjoyable.

Women's Health Policies

The WHPG is in the process of compiling a policy statement regarding competency and training for internal pelvic work. As internal evaluations are not part of physiotherapy undergraduate training, insurers will only pay for claims relating to internal pelvic therapy if a physiotherapist can prove that he or she has sufficient relevant training to be considered competent in a specific skill or treatment technique. Legally you must have done the correct training to be able to perform techniques.

Internal examination of pelvic floor muscles – a sensitive area

We are concerned that physiotherapists have been practising outside of their scope of practice as well as marketing themselves to doctors in a misleading way. In the interests of protecting both the profession and the public, the WHPG would like to clear up misunderstandings surrounding scope of practice in this field.

What defines the scope of practice with regard to the examination and treatment of the pelvic floor?

The WHPG has a clear policy outlining its expectations of pelvic floor examination procedure, indications, contra-indications and precautions. These expectations are focused on physiotherapists establishing and demonstrating their competence in assessment and treatment of the pelvic floor complex.

Internal examinations and treatment techniques are taught on the accredited WHP modules and strong emphasis is placed on the ethics around the procedure, as well as strict infection control measures, which are covered in detail before the actual physical examination is taught. Sound clinical reasoning principles are followed in interpreting the examination findings before an appropriate treatment technique is applied.

Risk management, in terms of competency, is also covered in the document and states that, should you be questioned about your ability to practise in an area of women's health, you must be able to demonstrate your competency by showing a record of appropriate education.

How do you know if you are practising outside of your scope?

Each course offers certain outcomes; by attending a course you have gained the knowledge and skills to achieve those particular outcomes. Should you perform an examination or technique which has not been taught on a course by an expert in the field you do not have the required skill set. You must have proof that you 'trained' in what you do.

What are the medico-legal implications?

Any malpractice claim is the individual's responsibility and a lawyer will require proof of the course attended and course outcomes which will indicate if you are qualified to perform the internal examination or treatment technique on that type of patient.

One WH module or course does not qualify you to treat all conditions, or to treat both males and females. It is your responsibility to ensure you can prove competence in the area in which you are working. The WHPG and SASP can only stand by you if you are able to prove you are practising within your scope as defined by your degree of competency.

How can you protect yourself against a malpractice complaint?

Signed consent from the patient is required; it is advised that you indicate the courses you have attended in order to declare your competence.

Patient information and informed consent should cover the risks and benefits of the pelvic floor examination and the assurance that treatment will be explained and discussed prior to commencing any intervention. The opportunity should be given for any questions or concerns the patient may have to be raised and adequately addressed.

Documentation – accurate record keeping of the assessment and/or intervention as well as any observations made. Should anything untoward occur it should be recorded.

Professional communication with the patient and the referring doctor or health care team should be evident.

How do you avoid a claim for pain and suffering from a patient who has been given incorrect or overly aggressive therapy?

The WHPG recommends that chronic pelvic pain, for example, should only be treated on completion of WHP modules 1 and 2, plus sufficient practice with peers. Then you will be able to validate your skill set and clinical reasoning should a complaint be received.

So… stick to your scope. It is your responsibility to ensure you have had undergone recognised training before performing internal examinations and comply with HPCSA rules and guidelines due to the medicolegal risk.

Expanding access in Gauteng

Dr Corlia Brandt joined the University of the Witwatersrand physiotherapy department at the beginning of 2018. She is a University of Free State graduate with a doctors degree in physiotherapy (Women's health and neuro-musculoskeletal therapy).

Currently she is developing a protocol to continue her post-doctoral studies on the neuro-musculoskeletal approach to Women's Health Physiotherapy, at the same time incorporating it into a model to develop women's health in South Africa (including the public and private sector, education, research, and clinical practice), bringing together all the different sectors.

During the first phase it is essential to determine the needs and capacity of each sector involved. In the second phase some training will be given to each sector and a model will be developed that can help to answer their needs, based on their available resources. WHPG could be involved in developing activities (for example online CPD activities) and presenting workshops to give the appropriate training and continued education based on the needs analysis.

In the third phase these models will be implemented, clinics established and efficacy monitored, with the potential for spreading the concept to other universities as well. Corlia has set up a database to collect information to be used in research at undergraduate and post-graduate levels. Here the WHPG participants

Continues on page 18

WHPG can get these laminated pelvic floor models at a discounted price if we are able to order enough. They are really useful teaching tools for your patients.

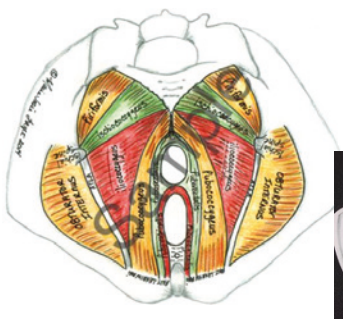
This fully laminated pelvic floor drawing can be folded into a 3D model measuring 24 x 21cm

It can be used to:

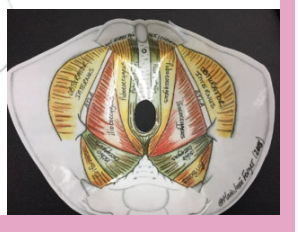
- learn the anatomy of the male pelvic floor
- improve your palpation skills which can be practised with the model (comes with opening for anus which allows actual palpation of muscles)
- visual aids in the clinical setting for teaching patients what and where their pelvic floor is
- the patient can hold the model while you examine them, so they can visualise what you are doing

We could get them at about R200 per model – if you buy it individually it will cost you about R250 + postage

If you are interested, contact Hester van Aswegen at hesterva@absamail.co.za.



This fully laminated pelvic floor drawing can be folded into a 3D model measuring 24 x 21cm.



who have done training in pelvic health will be able to do voluntary hours under supervision at these clinics (as field workers for clinical research projects) to fill the gap in helping the many patients that could benefit from women's health physiotherapy. At the same time they'll improve their own skills, deepen their experience in the field and contribute to evidence-based practice.

Currently Corlia has started educating the doctors and staff at Charlotte Maxeke Hospital, Chris Hani Baragwanath hospital and in the private sector about the patients who could benefit from a referral for WH or pelvic physiotherapy. Together with the clinical staff, she will be screening patients at the obstetrics and gynae clinic and maternity ward, to help identify patients who could benefit from referral and to set up the clinics.

Women's Health marketing and publications

One of the goals of the WHPG committee is to educate the public on the function of women's health physiotherapists.

In many of the South African communities there is very little knowledge about how to deal with pelvic floor problems and we have a huge role to fulfil to teach patients about their bodies and how to care for themselves.

Palesa Luvhengo promoted the role of women's health physiotherapy at a conference in Alex at the House of Prayer Bible Church on 9 June 2018. The theme was *Women of great achievements.* She did a talk on incontinence to 73 ladies, giving them an overview of the problem, why it happens, what to do to prevent it and adding some advice on back care and ergonomics. The women loved the demonstration of how to activate your pelvic floor muscles. Afterwards there was a question-and-answer session and prizes were handed out to the audience.

On 21 April 2018 WHPG Gauteng Committee member Shirin Motala presented at the Click's Baby Bootcamp event at Uncle Tom's Community Centre in Soweto. The event aims to provide education and advice to new and expecting parents on all things pregnancy, as well as baby and parenting related concerns. Shirin's presentation focused on the changes that occur in the female body during and after pregnancy and the role of women's health physio during this special time. The presentation was well received by the 200 attendees followed by an engaging question-and-answer session.

Current WHPG committee

Our current WHPG NEC consists of:

Megan Stephens – chairperson

Megan Stephens qualified as a physiotherapist in 2003 from the University of the Witwatersrand. She works in neuro rehab and has a special interest in pelvic health. She believes that education of the patient is the most important aspect of treatment!

Antoinette Jansen van Vuuren – treasurer

Antoinette graduated in 1991 at the University of the Free State. Her practice was established in 1995 and is situated at Netcare Pretoria East Hospital.

Antoinette has a special interest in female and male health as well as paediatric pelvic floor health.

Joh-Ann VD Merwe – secretary

Joh-Ann graduated in 2011 and currently works in Sinoville eand Hazeldean.

Her special interest is pelvic health, specifically sexual dysfunction and post-natal rehabilitation, but she also enjoys orthopaedic rehabilitation especially related to trauma.

They took over in 2018 and have big plans to take WHPG to new heights under their leadership.

This can only be done with the support of the various provinces and their representatives, as well as the WHPG membership.

We look forward to working together and promoting women's health and pelvic health physiotherapy, not only to the public but also other medical professionals.

Classifieds

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Somerset West: Permanent position available in mainly orthopaedic private practise. Contact 021 851 3156 or adfisio@telkomsa.net

Les Marais, Pretoria: Permanent position available for physiotherapist. Hospital as well as rooms work. Call 012 335 4351 or gerna@elsaprinsloo.co.za

Westrand: Vacancy junior & senior physiotherapist. We are a well-established multidiscipline physiotherapy practice based at a Life Healthcare hospital in the West Rand. We treat both rooms and hospital patients. We have vacancies for a junior physiotherapist as well as a senior physiotherapist with ICU experience. We offer a very competitive package and a friendly flexible work environment. If you would like to join our team, kindly email your CV to physio@bitcc.co.za or bruce@lukeandbarkerphysio.co.za

Pretoria: Locum or full time physiotherapist required for rooms work (predominantly orthopaedic, sports & musculoskeletal). Some hospital work (orthopaedic). Must be fluent in both English & Afrikaans. To commence July/August/September. Email CV to admin@tlphysios.co.za

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Update!

Please let us have any info you might want us to include in **Update** – anything of immediate news value, or which must be communicated urgently, related to Province, SIG or Portfolio news; student or comm serve news; and more. Send info to **mandiwrite@icon.co.za** by the 23rd of each month.

Members Benefit Programme

Members of the society can receive discounts from the following companies:

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Real-time booking platform and mobile app with an optional business management component. **A 16% discount will be offered to all SASP members.**

cNotes cNotes is an application designed to enhance the way you take clinical notes. It takes the advantages of working with pen and paper and merges them with the convenience of a digital tool that can be accessed from anywhere, at any time. **A 16% discount will be offered to all SASP members.**

PhysioTools
PhysioTools produces exercise software for professionals who need to create exercise programs and information handouts for their clients. Our software may be used from any device with Internet access to create personalised exercise programs with high-quality videos that can be emailed, printed or sent to PT Momentum - the exercise motivator App. This not only helps physiotherapists and other professionals to increase their efficiency, but also to improve customer experience and satisfaction. PhysioTools is easy to use, saves time and gives access to the world's largest library of exercises, for all areas of the body, created in co-operation with renowned authors, publishers and leading specialists in their field. The exercises may be delivered to clients in up to 28 languages. **SASP members receive a 16% discount.**

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Taping for Acute Oedema and Lymphoedema

Ask Leuko®

Part One

Clare-Anne Kilroe-Arouca
BSc Physiotherapy (Wits) OMT1 (South Gauteng)

The importance of swelling management is most evident when I see a patient who has not the advantage of post-operative physiotherapy, and struggle with a swollen, consolidated, and fibrotic joint. These joints have a powerful impact on the patient's functional capacity and pain levels later.

Hence, I wage war on swelling, but have learned to respect my adversary. We know that swelling is necessary to form the inflammatory soup made up of cytokines, bradykinins, and interleukins of required for healing, but excess swelling can disrupt function.

Oedema is a swelling of tissues caused by the increased permeability of the capillary blood vessels passing out excessive water into the surrounding tissues, and so increasing the intercellular fluid content. This can be as part of the healing process bit can but can indicate cardiac, renal, pulmonary or venous dysfunction. Not all swelling is water retention!

The most distinct feature of Lymphedema is the persistent accumulation of fluid and other elements especially the proteins in the interstitial tissue spaces due to an imbalance between the interstitial fluid production and resorption or transportation. Robyn Bjork defines Lymphedema as the "disruption of lymphatic flow which cause an accumulation of proteins in the interstitial space." Lymphedema is a high protein oedema. This protein odema disrupts the osmotic gradient and draws excessive fluid into the interstitial spaces. These proteins act as sponges and absorb and retain fluid in interstimium. Duiretics aggravate the abnormal osmotic gradient.

The aim of the treatment of the dysfunctional lymphatic system is therefore aimed more at restoring the osmotic balance than the reduction of the fluid.

This can be as a result of a congenital malformation of the lymphatic system, or acquired damage to the damage lymphatic vessels or lymph nodes.

The conundrum that exists is that these patients with lymphoedema often present with fibrotic consolidated swelling with soft tissue, wart-like protrusions. The manual therapist mind wants to break this down and alter the fibrosis with "manual force".

The irony of life exists in lymphoedema too – understanding replaces brute force every time.

The lymphatic system is a unique and wonderful system whose form complements its function. The two main take-home lessons are the related to the permeability of this system and the anchoring filaments which connect this system so intimately to the skin. These systems utilise "gentle" to achieve far reaching results.

Too much for one issue, see next issue for further details.

Please forward any queries or comments with respect to injuries, techniques or Leuko products to askleuko@bsnmedical.com for advice. 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.

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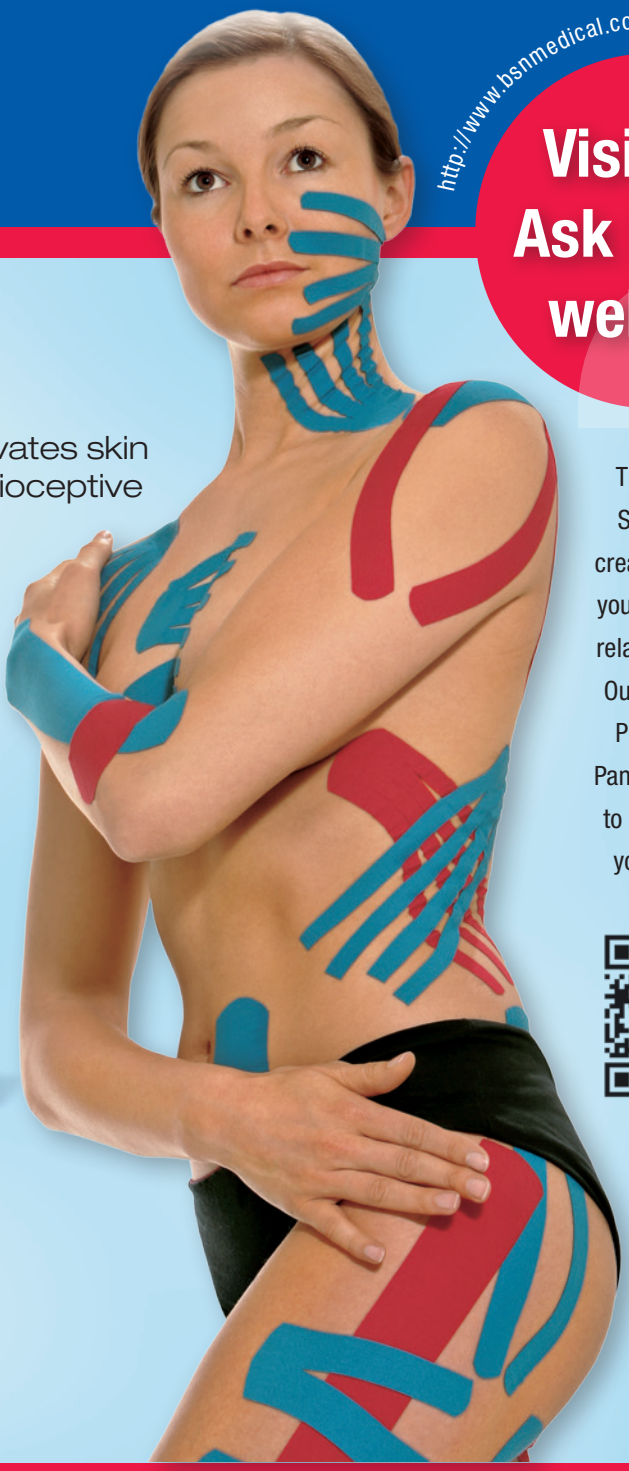
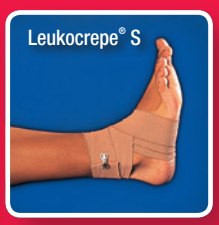
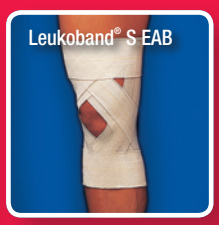


The AskLeuko Site has been created to answer your Sports Injury related questions. Our professional Physiotherapy Panel will respond to any questions you may have.

Scan me!





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OFFICIAL SUPPLIER TO THE SPRINGBOK RUGBY TEAM, BAFANA BAFANA AND THE NATIONAL MEN'S AND WOMEN'S HOCKEY TEAMS.

BSN medical®

REVOLUTIONARY SCAR SOLUTION

celltone SKIN CARE

We recommend our premium Celltone Tissue oil. Apply twice a day, morning and evening.

For faster results, we recommend our most powerful combination: Celltone Tissue Oil with Celltone Gel. Apply twice a day, morning & evening.

Morning and Evening: Apply Celltone Gel and allow to absorb for about 5 minutes. Follow with Celltone Tissue oil.

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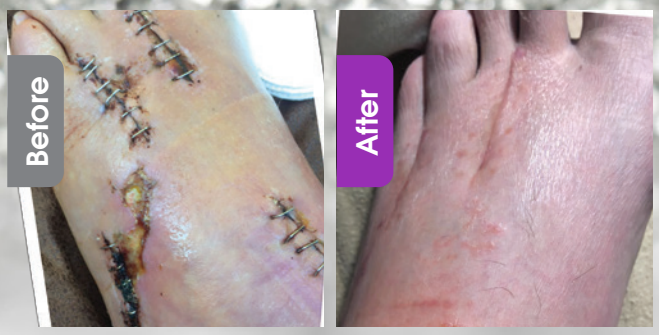
Celltone Tissue Oil is clinically proven to:

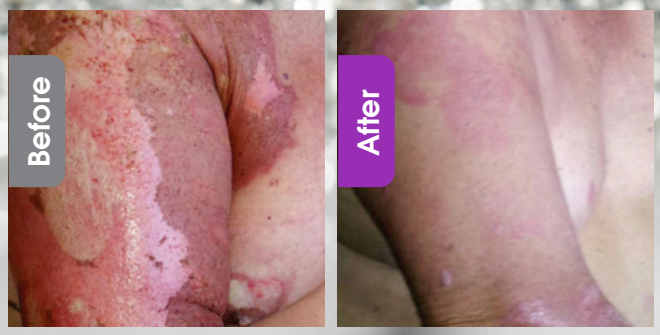
- **Reduce Scars**
  Reduce the width of scars after 14 days and lightens the appearance of scars after 6 weeks of continued use.

About Celltone Gel

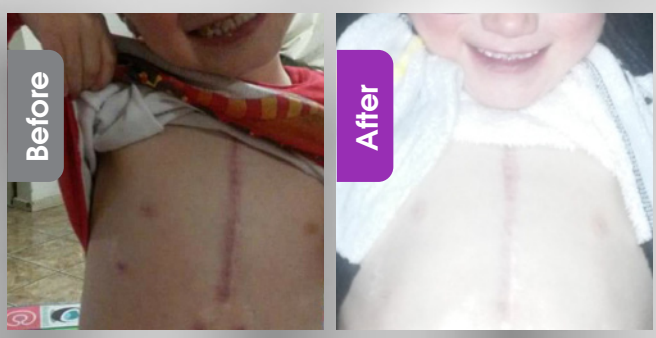
Years ago, workers at snail farms noticed how their hands became smoother and also how marks and scars diminished over time. Following research, it was discovered that Snail Extract contains a combination of natural ingredients that allows the skin to revitalise itself.



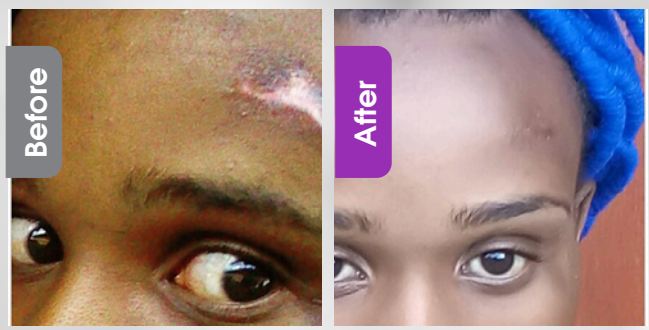
"I was in a serious motorbike accident. My foot was cut in multiple places. I used Celltone Tissue Oil and the results were astounding."
Peter R



"My skin was almost completely healed with minimum scarring after an accident involving acid. Celltone Tissue Oil was simply remarkable."
Tony A



"Wow! I am absolutely gobsmacked with Celltone Tissue Oil. My local pharmacy retailer recommended it when I needed a tissue oil for my son's scars after heart surgery. I decided to try it and the difference is amazing. What a fantastic product!"
C. Trollip



"I had a big scar because of a fall and dark marks all over my face, which affected my confidence as I was always being mocked. I saw the Celltone advert on TV and decided to start using Celltone Tissue Oil. After 7 weeks of using Celltone Tissue Oil my face looked so much better. Celltone is the best… I salute you!"
A. Ratsane

Celltone is available from **Dis-Chem, Game, Clicks, Red Square, Edgars, Checkers, selected Pick 'n Pay stores, City Medical, Pharmed, Med Pak** or directly from our website at **www.celltone.co.za**

www.celltone.co.za
Customer Care Line: 087 1600 357

E&OE.