Hip Dysfunction

- Common types of hip pain for NAT Hip
- 1. Arthritis, Post-operative stiffness
- 2. Labral tears & Femoral Acetabular Impingement
- 3. Groin Strain
- 4. Osteitis Pubis
- 5. Bursitis & Tendonitis
- 6. Snapping Hip Syndrome

Thomas Test

Labrum

- Labral tears - typically result from an underlying problem.
- They are actually pretty common with a prominent cadaver study (McCarthy et al) demonstrating at least one labral tear in 53or 54 specimens. Byers et al found the labrum was attached from the articular surface of the acetabulum in 88% of people over the age of 40.

- 1) Bony
- a. Static Overload from femoral antiversion, acetabular dysplasia (ant/lat) or valgus of femoral neck positioning
- b. Dynamic impingement CAM impingement, Pincer Impingement, Femoral retroversion
- 2) Soft Tissue Laxity (hypermobility - Ehers Danloss Trait), PSAOS impingement
- 3) Traumatic Dislocation, Subluxation

FAI

Normal Hip Anatomy

Lesions that occur with Impingement

People with FAI usually present with pain (or sometimes a dull ache) in the inguinal/ groin area and sometimes more toward the outside of the hip. Sharp stabbing pain may occur with turning, twisting, and squatting.

There are three types of FAI mechanism.

- 1) Cam deformity - An excess of bone along the neck of the proximal femur
- 2) Pincer deformity - Due an excessively deep socket or an abnormal tilt of the acetabular socket
- 3) A mixture of the preceding two forms (most common scenario).

Groin Strain

2-5% of all sports injury

- Adductor strains and osteitis pubis are the most common musculoskeletal causes of groin pain (in athletes).
- Most common in athletes that play sports like hockey, ice hockey, fencing, handball, cross court skiing, hurdling & high jump; it may comprise 5-7% of all soccer related injuries (Westlin 1997). The diagnosis is complicated and may remain unclear in 30% of cases (Ross 1997).

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Osteiitis Pubis

Osteiitis Pubis Presenting Symptom Area	
Adductor pain	80 percent
Pubic symphysis	40 percent
Lower abdominal pain	30 percent
Hip pain	12 percent
Referred scrotal pain	8 percent

***American Family Physician October 15, 2001, Vol 64, No 8**

- Characterized by symphysis pain and joint disruption.
- It may be difficult to distinguish from adductor strains, and the two conditions may occur concomitantly in the same patient.
- Factors, such as limitation of internal rotation of the hips or fixation of the sacroiliac joint, also place excessive stresses on the joint. Leg length discrepancy and valgus or varus of the hip or knee may also play a factor as well as abnormal Q-angles.
- Clinically, the patient reports exercise-induced pain in the lower abdomen and medial thigh. Symptoms are gradual in onset, slowly increasing in severity if activities are not stopped

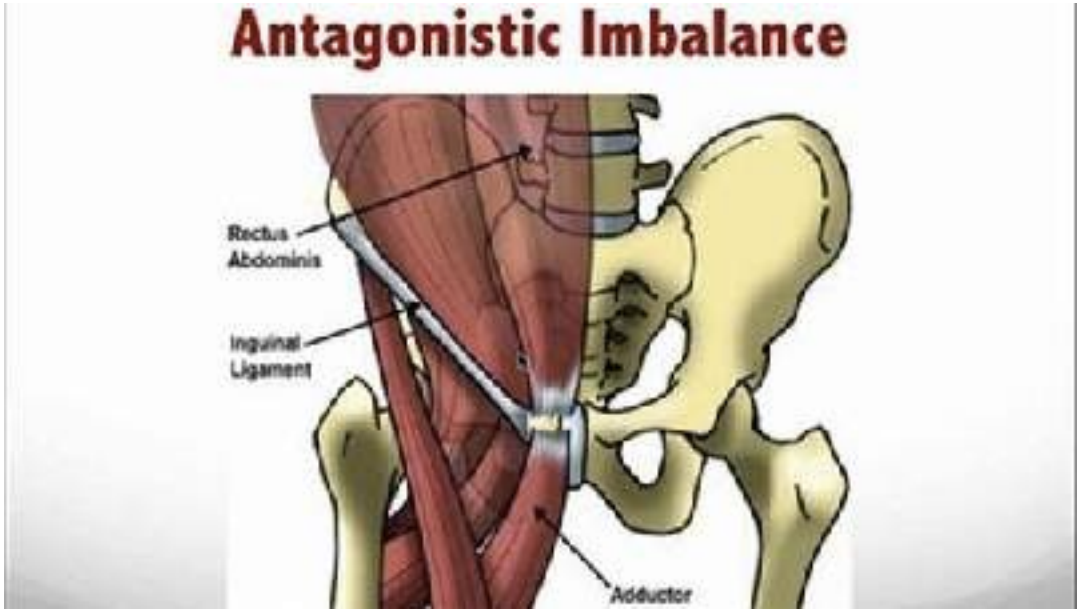
PREDISPOSING FACTORS TO THE NAT HIP/ARI HIP

- FRUSTRATION: current model of dealing with hip dysfunction especially overwhelming gluteal hypertonicity and global restriction of ROM.
- 2 types of athlete – straight line or random movement (hockey)
- SUPER TRIGGER POINTS IN CLOSE PROXIMTY TO ILIOFEMORAL JOINT CREATING A CHANGE IN RECIPROCAL INHIBITION RELATIONSHIPS.
- ENDUARANCE THRESHOLDS – gradual changes in athletes, load management. Problems when push through
- ADAPTATION – Neuroplasticity
- ALTERED MOVEMENT PATTERNS – is the outcome – then we apply sequence

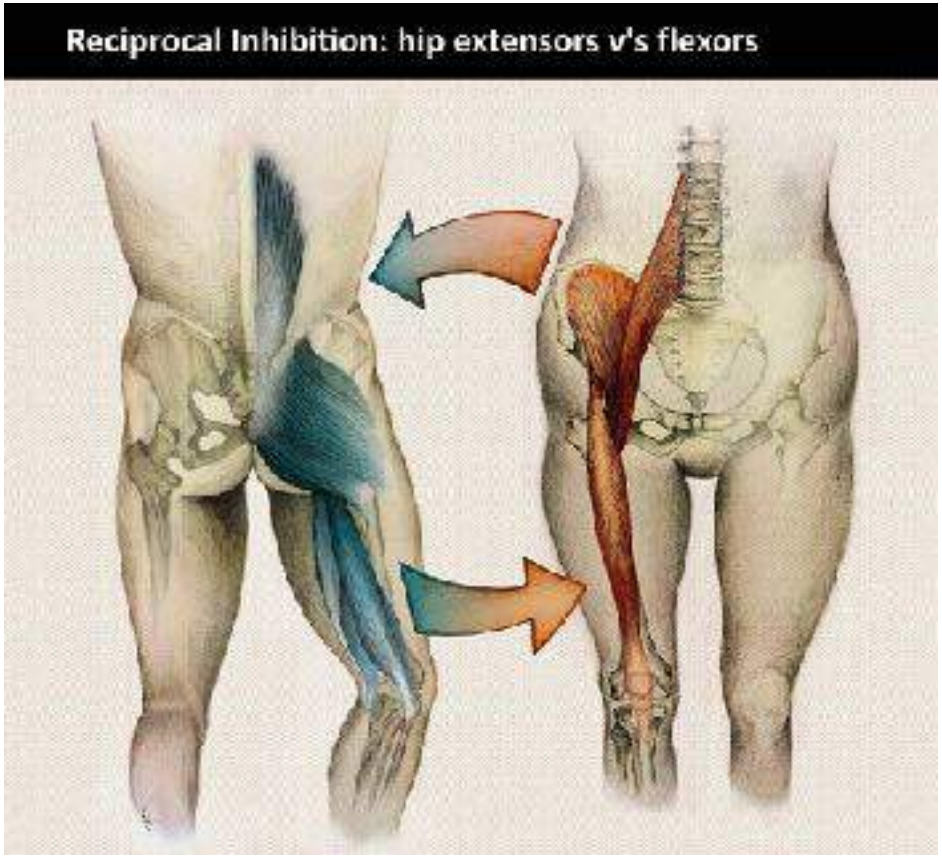
Hip Holding

ALTERED MOVEMENT PATTERNS

- In the case of prolonged sitting, the antagonist tight hip flexors are causing inhibition of the agonist gluteal muscles.
- When the agonist and antagonist are in perfect balance, the light dimmer is shut off, allowing the light to be at full brightness. This allows for both muscles to be at full contraction and full range of motion (ROM). Blumberg et al.



Reciprocal Inhibition



HIP EXTENSION

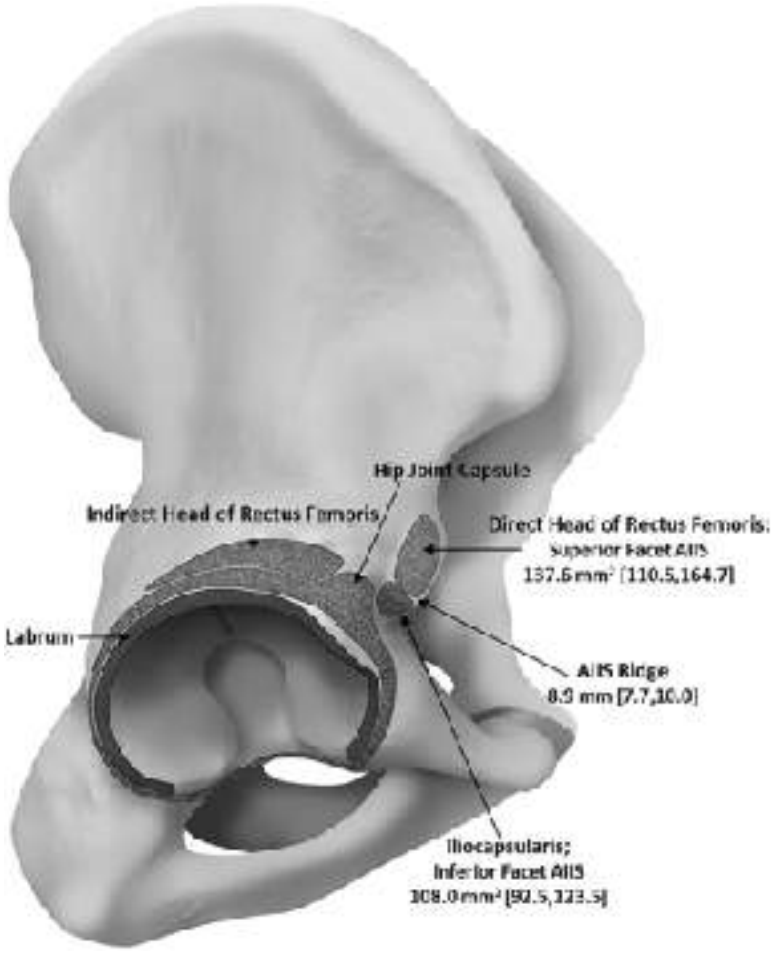
- PRIME MOVERS –
- GLUTEUS MAXIMUS
- HAMSTRINGS
- ERECTOR SPINAE

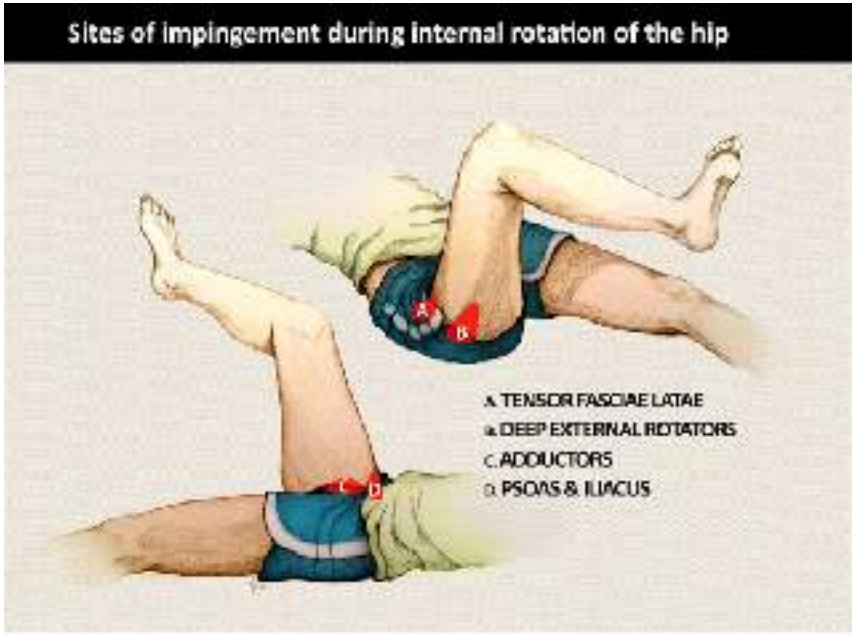
- THE MAIN RESTRICTOR –
- TIGHT /OVERACTIVE FLEXORS
- INHIBITS GLUTEUS MAX/MEDIUS

Important Structures

- **Hip Adductor Group**
- **Iliopsoas**
- **Gluteus Maximus**
- **Hamstrings and Biceps Femoris**
- **TFL**
- **Lumbar Erector Spinae**
- **Small Hip Muscles**

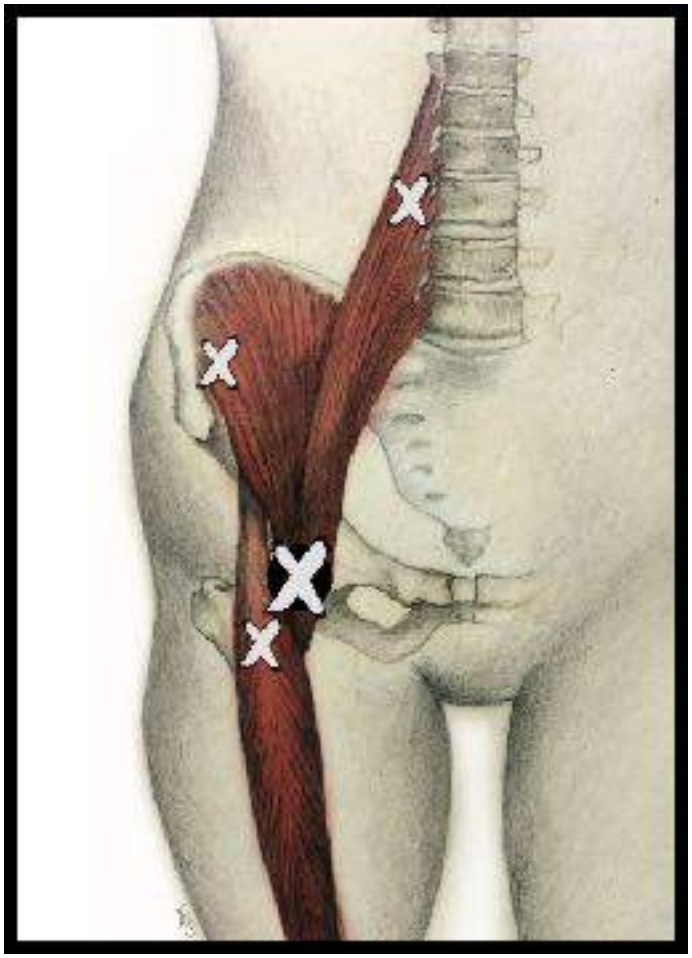
Areas of dysfunction



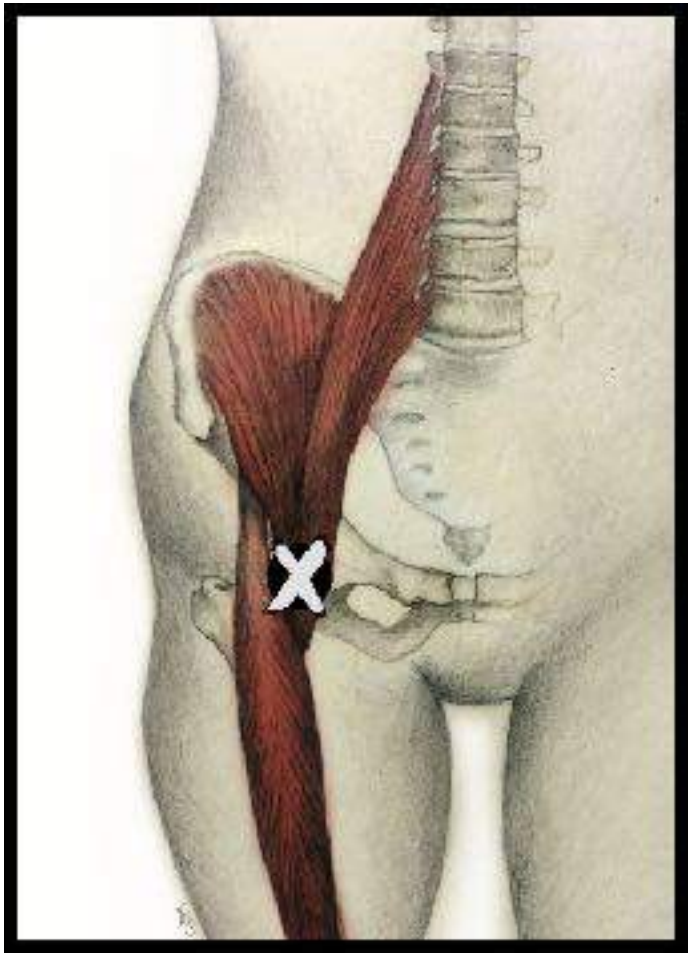


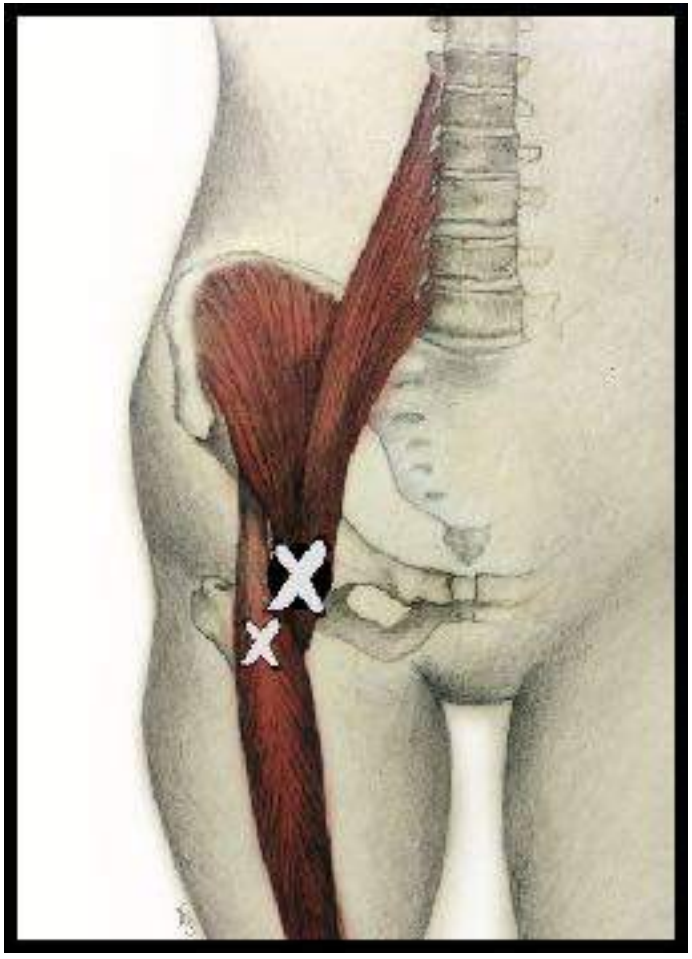
HIP EXTENSION ASSESSMENT

Testing the Psoas

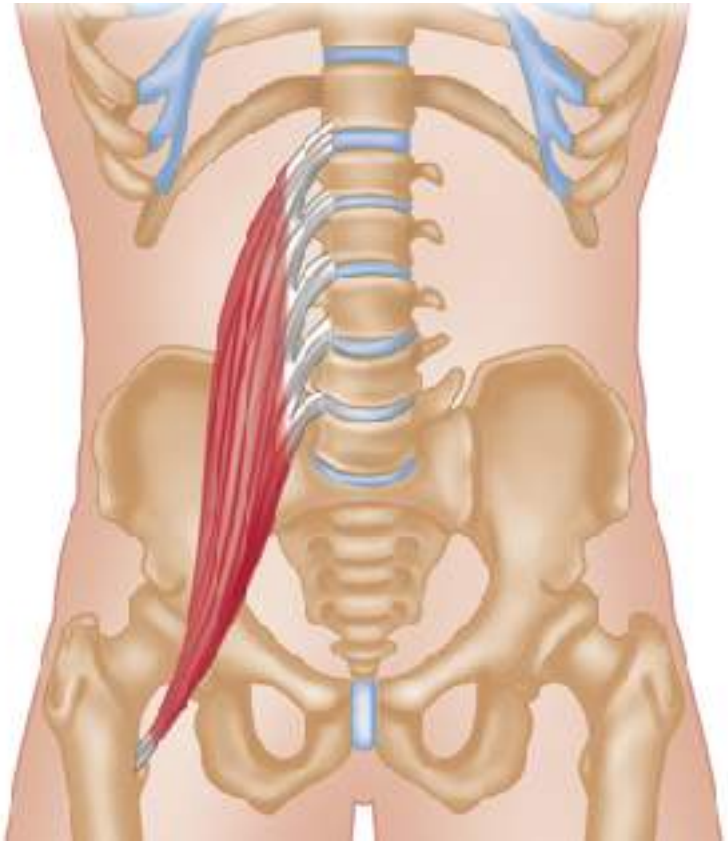


ILIOPSOAS /RECTUS FEMORIS





Iliopsoas



ORIGIN

- Psoas major: bases of transverse processes of all lumbar vertebrae, (L1–L5). Bodies of 12th thoracic and all lumbar vertebrae, (T12–L5). Intervertebral discs above each lumbar vertebra.
- Iliacus: superior two-thirds of iliac fossa. Internal lip of iliac crest. Ala of sacrum and anterior ligaments of lumbosacral and sacroiliac joints.

INSERTION

- Psoas major: lesser trochanter of femur.
- Iliacus: lateral side of tendon of psoas major, continuing into lesser trochanter of femur.

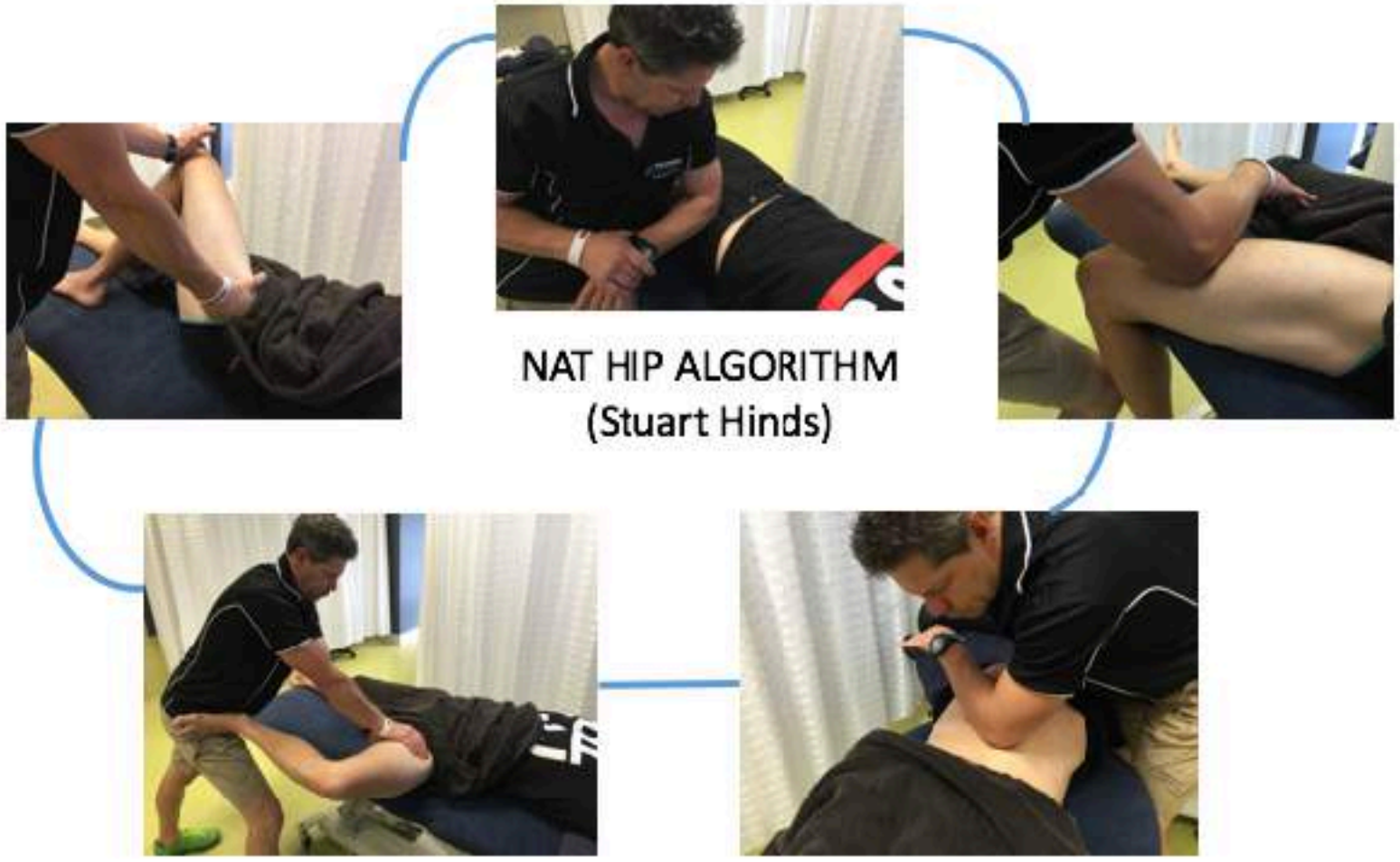
ACTION

- Main flexor of hip joint (flexes and laterally rotates thigh, as in kicking a football). Acting from its insertion, flexes trunk, as in sitting up from the supine position.
- Antagonist: Gluteus Maximus.

NERVE

- Psoas major: ventral rami of lumbar nerves, L1, 2, 3, 4 (psoas minor innervated from L1, 2).
- Iliacus: femoral nerve, L1, 2, 3, 4.

NAT Hip Algorithm



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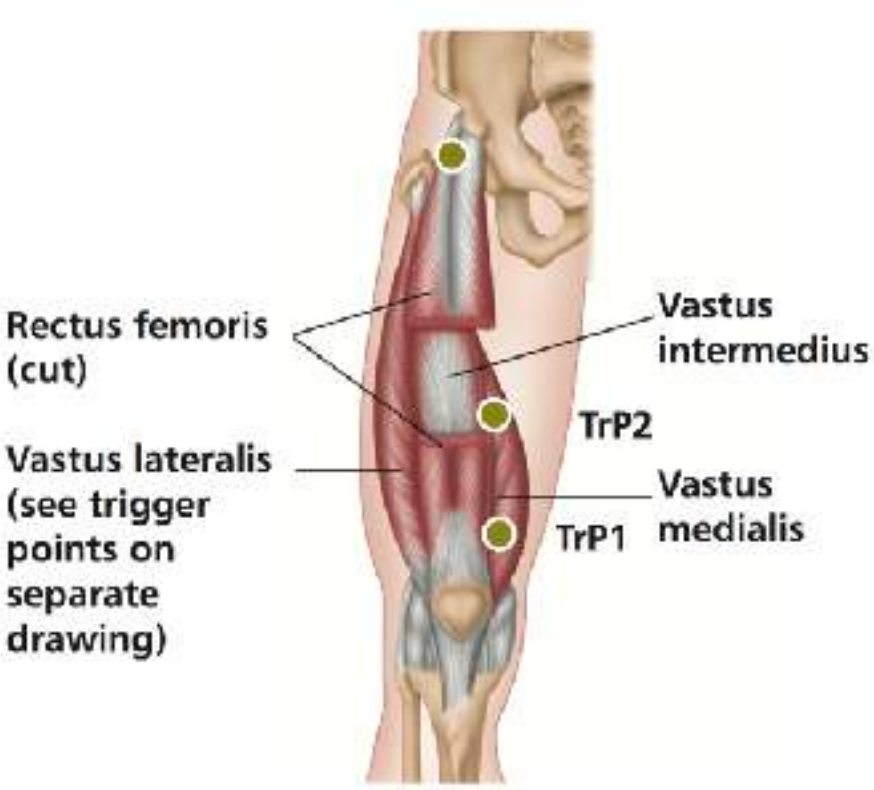
STEP 1- HIP EXTENSION- ILIOPSAOS TREATMENT

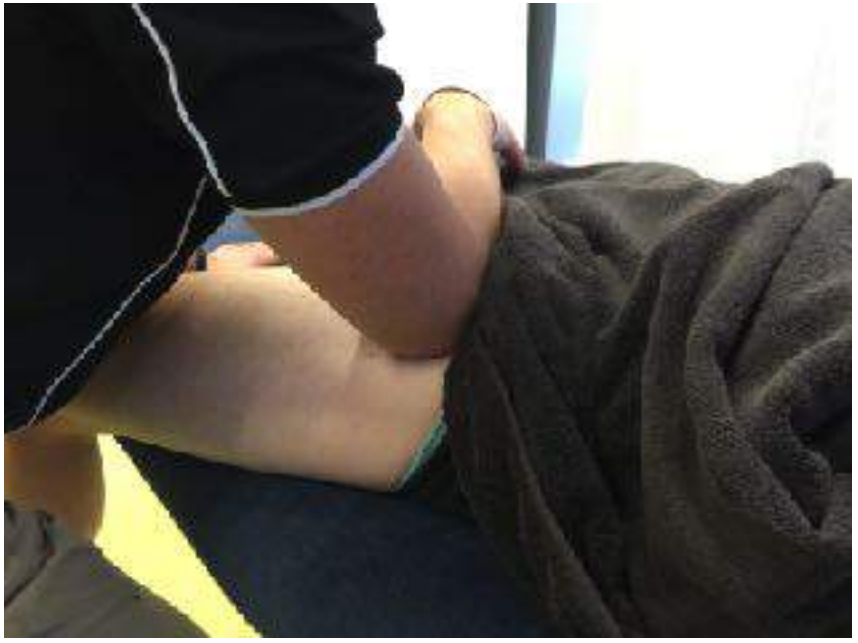
The Quadriceps



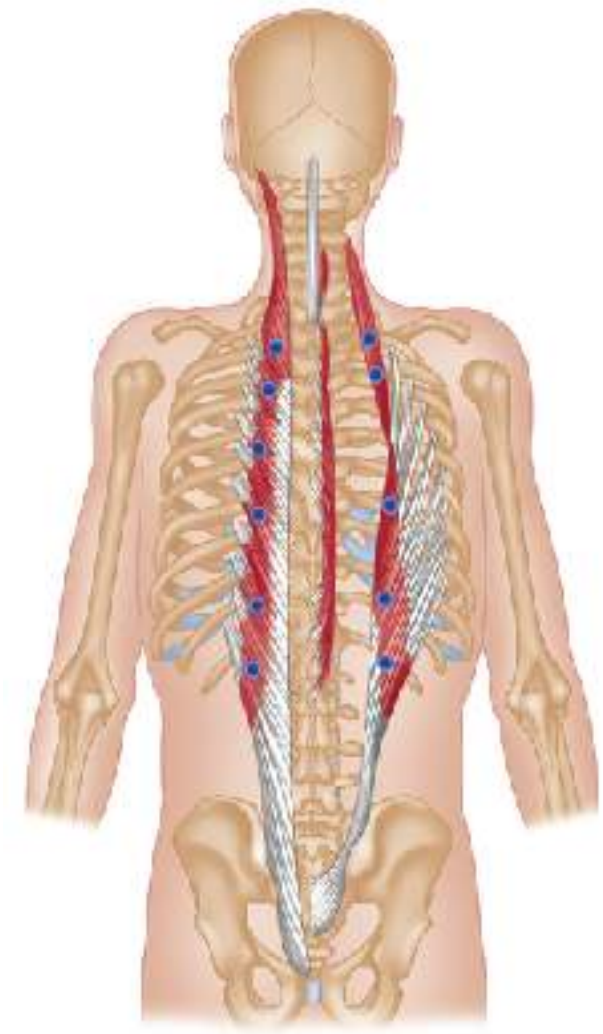
- **ORIGIN**
- **Vastus group: upper half of shaft of femur. Rectus femoris: front part of ilium (AIIS). Area above hip socket.**
- **INSERTION**
- **Patella, then via patellar ligament into upper anterior part of tibia (tibial tuberosity).**
- **ACTION**
- **Vastus group: extends knee joint. Rectus femoris: extends knee joint, and exes hip joint (particularly in combination, as in kicking a ball). Antagonists: hamstrings.**
- **NERVE**
- **Femoral nerve, L2, 3, 4**

HIP EXTENSION- RECTUS FEMORIS MYOFASCIAL TENSION TECH

HIP EXTENSION-RECTUS FEMORIS TREATMENT



Erector Spinae



ORIGIN

- Slips of muscle arising from the sacrum. Iliac crest. Spinous and transverse processes of vertebrae.

INSERTION

- Ribs. Transverse and Spinous processes of vertebrae. Occipital bone.

ACTION

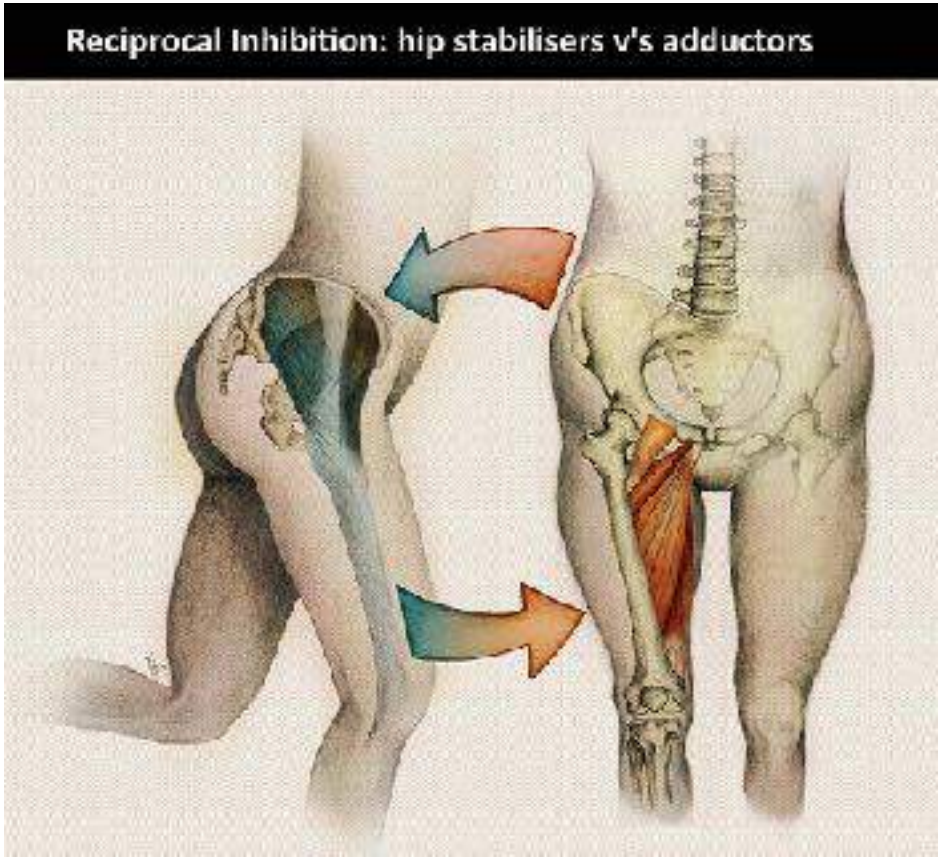
- Extends and laterally flexes vertebral column (i.e. bending backward and sideways). Helps maintain correct curvature of spine in the erect and sitting positions. Steadies the vertebral column on the pelvis during walking.

Antagonist: rectus abdominis.

NERVE

- Dorsal rami of cervical, thoracic, and lumbar spinal nerves

HIP EXTENSION -THORACO-LUMBAR TREATMENT .



ADDUCTORS:

HIP ABDUCTION ASSESSMENT

Gluteus Medius

- **ORIGIN**
- **Outer surface of ilium inferior to iliac crest, between posterior gluteal line and anterior gluteal line.**
- **INSERTION**
- **Oblique ridge on lateral surface of greater trochanter of femur**
- **ACTION**
- **Abducts hip joint. Anterior fibers medially rotate and may assist in extension of hip joint. Posterior fibers slightly laterally rotate hip joint. Antagonists: lateral rotator group.**
- **NERVE**
- **Superior gluteal nerve, L4, 5, S1.**

Pectineus

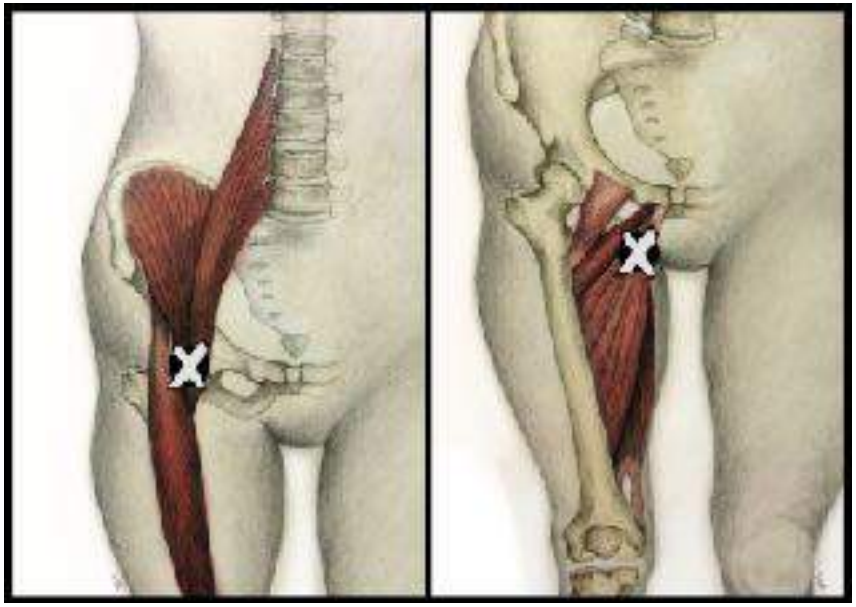
- **ORIGIN**
- **Pecten of pubis, between iliopubic (iliopectineal) eminence and pubic tubercle.**
- **INSERTION**
- **Pectineal line, from lesser trochanter to linea aspera of femur.**
- **ACTION**
- **Adducts hip joint. Flexes hip joint.**
- **NERVE**
- **Femoral nerve, L2, 3, 4. Occasionally receives an additional branch from obturator nerve, L3.**

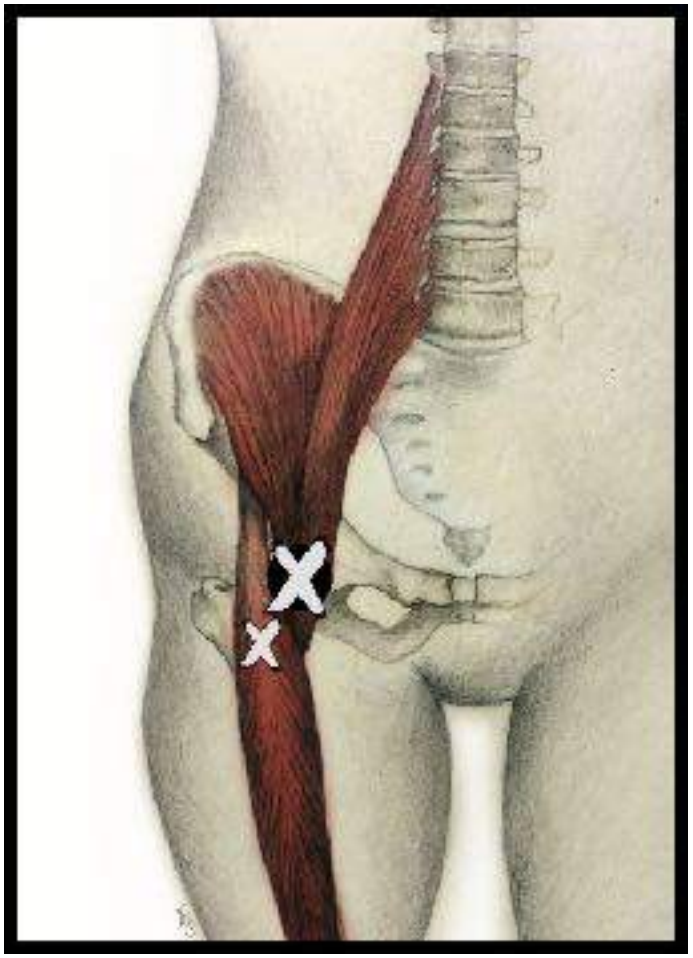
STEP2 GLUTEAL / ADDUCTORS – HIP ABDUCTION TREATMENT

INTERNAL ROTATION

- The final piece in the jigsaw.
- Our opportunity to address underlying restrictions
- TREATMENT SEQUENCE
- STEP 1- HIP EXTENSION
- STEP 2- HIP ABDUCTION
- STEP 3- INTERNAL ROTATION
- CHASE THE RESTRICTION
- ANTAGONIST CONTRACTION- EXTERNAL ROTATION.

ILIOPSOAS/ ADDUCTOR MAGNUS





Hip Adductor Group

Adductor magnus posterior view

ORIGIN

- Anterior part of pubic bone (ramus). Adductor Magnus also takes origin from Ischial tuberosity.

INSERTION

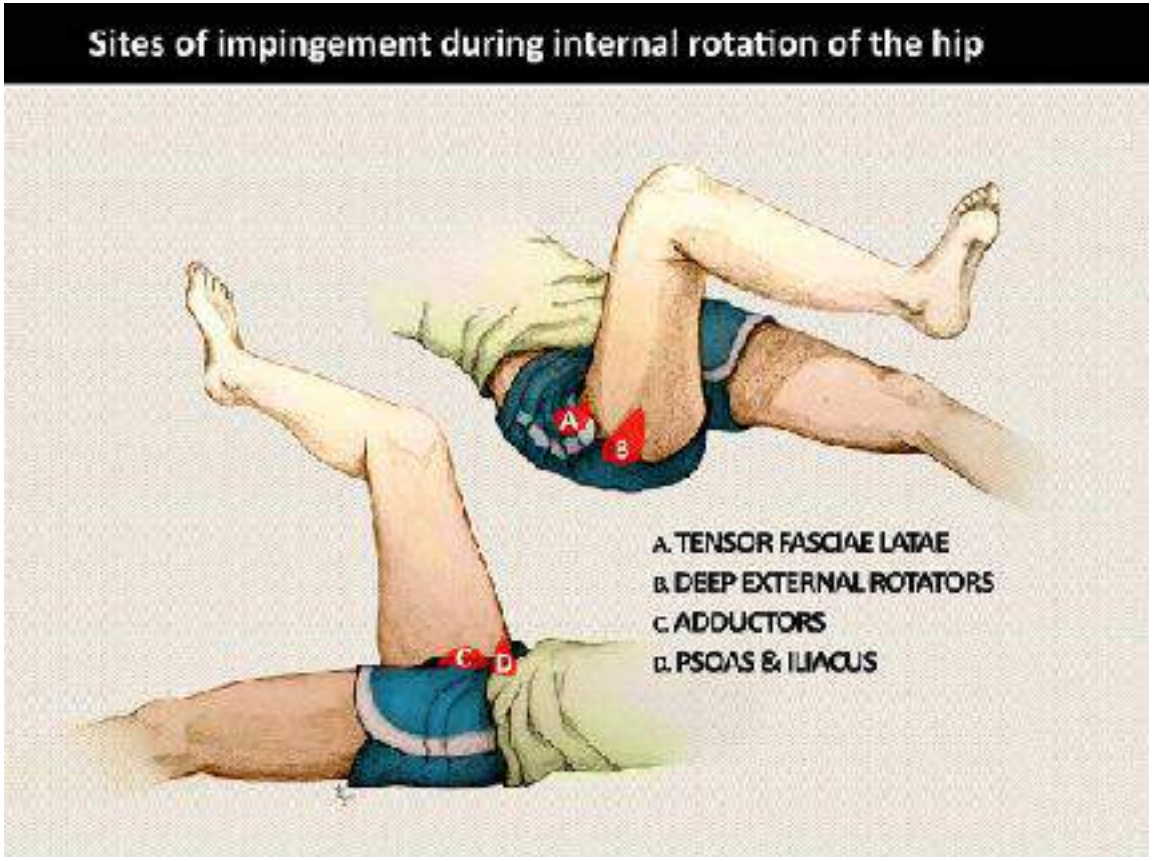
- Whole length of medial side of femur, from hip to knee.

ACTION

- Adduct and laterally rotate hip joint. Adductors Longus/ Brevis also flex extended femur and extend flexed femur.

NERVE

- Magnus: posterior division of Obturator nerve L2, 3, 4. Tibial portion of sciatic nerve, L4, 5, S1.
- Brevis: anterior division of Obturator nerve, (L2–L4). Sometimes the posterior division also supplies a branch to it.
- Longus: anterior division of Obturator Nerve, L2 , 3 , 4 .



INTERNAL ROTATION ASSESSMENT

Restrictions sites
1)TFL 2) Gluteus medius 3) Adductors 4) External rotators
5) ilipsoas/Rectus Femoris

Tensor Fascia Lata (TFL)

ACTION

- Upper fibers: laterally rotate hip joint. May assist in abduction of hip joint.
- Lower fibers: extend and laterally rotate hip joint (forceful extension as in running or rising from sitting).
- Extend trunk. Assists in adduction of hip joint. Through its insertion into IT tract, helps to stabilize knee in extension.

Antagonist: **Iliopsoas.**

NERVE

- Inferior gluteal nerve, L5, S1, 2.

EXTERNAL ROTATORS

TENSOR FASCIA LATAE

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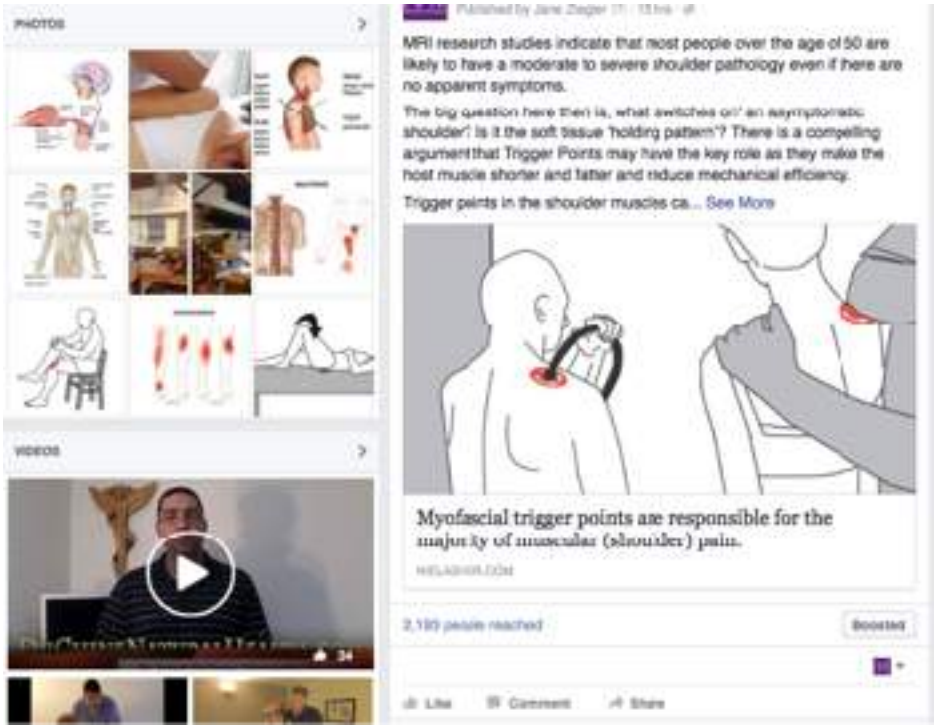

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Troubleshooting & FAQ's

What equipment do I need?

Nothing Special – just your hands and some cream; please try to avoid adding modalities at this stage of your training. UP/DOWN treatment couch (optional) preferably with face-hole (optional). Foam wrist support. Models of shoulder (optional). Goniometer. Creams (BLUE NIVEA). Clinical testing equipment.

What creams or lotions should I use?

In general it is better to avoid oils as they may cause you to slide off from the pressure points once you have found them. We generally use plain blue 'Nivea' cream. Alternatively: Arnica cream, Plain Aqueous cream (with a few drops of vitamin E – food quality oil), Petroleum Gel, Massage oils/ liniments may be used.

NB/ always ask if you or your patient has a Lanolin allergy, or an allergy to any of the above.

NB/ be aware of any open skin wounds or skin lesions before applying creams or lotions.

What handhold do I use?

- I use my elbow for treating the pressure points. This is because it allows me to generate more force. This is something that you can try, but at the beginning you may tend to slip – so go slowly. You can try using your thumb re- enforced with your other hand.

How much pressure (FORCE) do I use?

- This is something that comes with experience but as a rule of thumb; the more painful the tissue the slower and deeper the pressure. In all cases the key words are 'work slowly' and 'thoroughly'.
- Another factor which determines the amount of force which you should apply is the – Muscle type (red/white fiber) and morphology of the patient. This will affect the depth of treatment. If the patient is 'stocky' I would expect to have to work quite vigorously, especially into the posterior capsule. If they are slight, you won't need to use as much force to affect a change in the tissues.

How fast do I go in STEP 1 (VELOCITY)?

- This depends somewhat on what you want to achieve. Varying the speed of the stroke can do the following:
- Faster – is more stimulatory and it is especially useful in a phase III treatment or in general n the last few treatments sessions to 'ramp-up' abduction
- Slower and deeper – is more useful for the stubborn, stuck or diabetic shoulder

What is the direction of force?

- The direction of force varies slightly from person to person. In general the aim is to reproduce the painful symptoms. When you find the painful nodules and with a sustained pressure change or vary the direction of force; see the effects that this has on the pain. We want to find the direction of pressure, which, where possible reproduces the exact pain that the patient experiences.

Troubleshooting & FAQ's

Does the treatment stop the frozen shoulder?

- In an early phase I case without masses of inflammation the answer is – 50:50.
- It is our experience that little can be done to stop a frozen shoulder developing once the process has started in earnest.
- The treatment we are advocating seems to accelerate the condition through its phases rather than stop-it in its tracks.

Steroid injections?

- In about 5-10% of phase I cases, I recommend one or a series (up to three) local steroid injections into the front and back of the joint. Preferably these should be ultrasound guided.

What would be my course of action if the patient had not improved in:

- (i) six weeks? (ii) two months?
- For those of you who are against this type of intervention - patients should not need this.
- Practically speaking, however, some patients are in so much pain (due to the massive amounts of inflammation) that it may be more expedient in some cases to follow this route – you must use your own discretion.
- This depends on the phase at which the patient presents. If they are in phase I and in a lot of pain and. If there is no change after 5 sessions; If the night pain is still extremely severe.
- Firstly you should thoroughly explain the natural history and pathogenesis of the condition. This is to put the patient at ease as much as possible, remember, they are scared and often in very bad pain. Then we would refer-on to a colleague (orthopedic physician) for further investigation and or steroid injection. If investigations etc... were NAD, we would continue with our treatment program. If the (night) pain was still extremely severe, we might refer the patient for either a course of Amytryptaline, Lyrica or a suprascapular nerve block (Guinethedine) – this is rare. We have, thankfully, never needed to recommend manipulation under anesthetic (MUA) which has a very poor evidence base.

Is there a pattern in which mobility returns?

- Yes. This depends on the phase and/or presentation (A/P/L). As a rule simple movements come back first. That is why we measure 'pure' simple passive ROM. Complex movements should start to return after this: From the 8th session – pre-phase I/phase I From the 5th session - phase II From the 3rd session - phase III

Troubleshooting & FAQ's

My patient is complaining that they still can't reach behind their back. How can I increase the range of motion for getting the arm up behind the back (APLEY)?

•The APLEY maneuver is always the 'last to return' There is a very potent trigger point. In the biceps belly which can accelerate a return for this movement pattern. Ideally this should be used towards the end of the treatment cycle, once the range of motion is above 160° flexion.

•As a result of the granulomatous LHB inflammation, the whole of the biceps muscle becomes shortened and fibrotic. In my opinion this is the major limiting factor for internal rotation and the APLEY maneuver.

•Inhibition to the trigger point in **the biceps belly** should be used to rapidly increase the APLEY range of motion.

Pain Thresholds!

•Patients have different pain levels/thresholds, this has to be taken into account. One of the facts about FS is it occurs in patients with lower pain thresholds or central sensitization. This may be due to the fact that they are more frightened to move the injured arm and it thus seems to 'freeze' more quickly.

Ice and Splinting

•Patient might benefit from using Ice and Heat at night on the front of the shoulder (region of the biceps tendon) before they go to sleep.

•On no account should the patient stop using or splint the arm, if anything he should be encouraged to do daily ROM exercises.

Treatment reactions / side effects:

- The majority of people (70%) have a reaction to treatment after a session. Treatment reactions are a natural part of the overall effect of NAT therapy. We have become accustomed to going to the doctor and receiving a pill or remedy, which usually works within a few hours.
- Osteopathy seems to work differently. NAT taps into the bodies own healing mechanisms and these often take a few days to adjust and re-balance. Curiously, from research it seems that the worse the treatment reaction the better the improvement which seems to follow it! (JACM April 1997 & June 1997)

Some common side/treatment effects:

- Tiredness
- Headache
- Local post treatment soreness
- Changes in bowel movement (diarrhea or constipation)
- Increased urinary frequency
- Joint aching ('flu-like) and/or increased pain for about 24-48 hours
- Some people feel emotional, vulnerable and/or tearful

Note: A treatment reaction commonly lasts for two-three days.

Troubleshooting & FAQ's

How do I structure a typical appointment?

In our clinics we spend half an hour per session. This is for the first session and each subsequent session. We will attempt here to take you through typical treatment session sequences for unilateral and bilateral presentations; we will give you an indication of the time each STEP might take. We will also explore the nuance and variation at different stages in the treatment cycle.

Pre-Phase I

•You are most likely to see a phase 0-I presentation in patients who have seen you before with a previous frozen shoulder. This is because they know the signs. In such a case the patient may not have lost all mobility, in fact they may well have almost all of their range of motion. As discussed previously, in my opinion there is a 50/50 chance of 'nipping' the frozen shoulder in the bud. In the other cases you can 'speed' the shoulder through its course – the key diagnostic difference between these is the time elapsed since onset and the amount of inflammation in the joint.

Phase I

- Once per week for 5 weeks then, depending on inflammation levels once every week.
- This should take three to five sessions to lessen the inflammation (measured by less or no night pain) followed by five to seven sessions to regain the range of motion.

Phase II

- Once a week for 7-8 weeks or more often if required.
- This should take three sessions to lessen the inflammation (measured by less – no night pain) followed by three to five sessions to regain the range of motion.

Phase III

- Once a week for three to five sessions or more often (every three to four days) if required.
- This should take three to five sessions.
- As a rule 85% of cases can be treated in less than eight to ten sessions.

Managing expectations

Management

When a patient presents around the peak of phase I (sharp, catching pain, restricted movement, sleep disturbed ++) we would initially like to see them once weekly for the first three to four weeks. Initially we are looking for a reduction in night pain and sharp, catching pain. Initial relief often only lasts one to two days post treatment, then symptoms slowly return. It is important to let patients know this is what to expect, otherwise they are quick to become disheartened, especially if they have tried numerous other treatment approaches. With each successive treatment, we would expect to see a longer resolution of symptoms, such that by the third, if not fourth, treatment the patient reports a definite improvement.

They are aware they are sleeping better and the sharp, catching pain is largely gone and they usually report a reduction in use of analgesia/NSAIDs.

Managing expectations

Once a patient has reached this stage we like to spread the treatments out to two weeks apart and introduce some strengthening exercises. It is imperative the patient stays within the pain-free range and doesn't overdo it as this just seems to aggravate the shoulder. Exercises should initially be introduced every other day and ice used post-exercise if there is any soreness. Emphasise that if the exercises are done correctly (and introduced at the appropriate point) there should be no pain either during or after exercise. Pain generally indicates the patient is doing the exercises wrong – usually trying to push through too great a range.

Once pain has gone, the range of motion starts to return. Once the pain is gone the patient is in phase II (the restricted or frozen phase). After seeing the patient roughly three times at two-weekly intervals we would spread the treatment to three to four weeks apart, increasing the number and intensity of the exercises. In a non-complicated frozen shoulder presenting at the peak of phase I, we would expect to see them eight-twelve times from initial presentation to complete resolution. Paradoxically, the later in the condition they present, the easier it is to treat.

Manual therapy

- Joint and soft tissue mobilisation techniques have been shown to augment the effect of the exercise program.
- Initially, supervised exercises with manual therapy is recommended. During that time patients should be instructed in a home programme.
- We have found it necessary to watch the patient doing their exercises for 3-4 weeks running to ensure they are able to do them correctly and understand what is correct movement.

As patients progress treatment is spaced further apart and patients can move entirely to a home programme when they no longer are in need of manual therapy.

Patient advice sheet

Managing Frozen Shoulder – What You Can Do To Help Yourself

Daily Living

What you do with your shoulder on a daily basis is important both for managing pain and increasing the rate of recovery. The instinct we have when something is hurting is not to use the painful area. Where as this may be appropriate for other problems such as a fracture or ligament sprain, it is not so for a frozen shoulder.

Although instinctively all frozen shoulder sufferers want to cradle their arm in the sling position, it is very important to avoid doing so as it only compounds the problem. Immobilising the arm, however tempting it may seem, just causes greater shortening and stiffness and in the long term will slow down recovery. Try to keep the arm straight allowing the arm to hang alongside your body. In this position the weight of the arm acts as a gentle traction force, stretching the biceps tendon and slightly separating the shoulder joint.

Wherever possible it is important to try and use the arm as normally as possible, but within the pain-free range, avoiding those activities that you know will cause that sharp catching pain. Try swinging the arms when walking; don't just hold the arm rigid. Try putting your arm up on the sofa when you are sitting. If you are standing, try sliding your hand up the wall, but remember to keep your shoulder relaxed. Don't be afraid to move your arm, you will not make it worse, just try to avoid tweaking the tendon,.

Patient advice sheet....

Walking

When walking through a busy supermarket or going on public transport it may be very difficult not to remain tense and protective towards the shoulder for fear of someone knocking into you. However, whenever possible it is important to allow the shoulder to relax and straighten the arm when walking. The tension caused by fear of pain will only compound the problems.

This is what to do when ***walking***:

- Relax the shoulder down.
- Straighten the arm.
- "Let it swing", swinging the arm along the side of your body like you would under "normal" circumstances. It may feel odd initially but if you persevere, you will soon get used to it.
- Breathe and relax.

Swinging the arm during a very acute phase may be painful, so achieving the first two points is enough. Just remember that the pain is not due to an injury (in which case immobility would be appropriate), but largely due to the immobility, so movement will actually make it better! The more you move the arm within the pain-free range, the larger the pain-free range will become.

Patient advice sheet ….

Sleeping

Night pain and sleeplessness are some of the worst aspects of the frozen shoulder, especially in the early days. At first, you will probably not be able to tolerate pressure on your affected side. As your symptoms ease, however, you will find you can gradually ease into some type of position. The degree of night pain is directly proportional to the amount of inflammation within the joint. Some comfort and relief may be obtained by:

- Lying on your back, with a pillow lengthways under the affected arm(s) and shoulders, supporting them.
- Lying on the good side with a pillow or towel over your waist and under the arm. Try to avoid sleeping with the arm above your head. This inhibits shoulder tissue repair, which mainly occurs at night.
- Lying on your back with a good neck pillow.

Patient advice sheet ….

Ice

Ice can be particularly beneficial in the acute, freezing phase (I) when the inflammation is most active. You may feel sceptical about this, but so many people have enthusiastically described the relief they felt from applying ice to their shoulders that it is worth trying.

- Wrap some crushed ice or frozen peas in a towel and place over the front of the shoulder joint.
- Leave it there for five to ten minutes.
- Let the area rest without ice for five to ten minutes and repeat.

The cycle can be repeated four to five times and can be done several times during the day. You can also apply the ice to the back of the shoulder joint, the top, the side or other areas where there is acute pain. It is a good idea to ice the front of the shoulder even if it is not painful.When ice is not appropriate (at work etc) then cold sprays or gels may be useful.

NB: never apply ice directly to the skin as it burns and leaves brown marks.

Patient advice sheet ….

Heat

In the early stages of a frozen shoulder applying direct heat is not a good idea, though a warm bath may be helpful. Warm packs / hot water bottles that are not too hot can be applied in the second and third phases, and this is particularly beneficial prior to attempting any stretching exercises. If you find that heat does give you temporary relief, then an alternating cycle of five minutes ice, five minutes warmth, ending with five minutes ice can be tried. It is very important to end the cycle with ice.

Posture

The benefits of maintaining a good posture are something that we Osteopaths often try to emphasise to our patients. Round shoulders and long term poor posture causes the shoulder muscles and joints to work inefficiently and can lead to a “pinching” of the tissues; causing further damage. The neck muscles are also vulnerable in frozen shoulder as they often go rigid in a frozen shoulder where they are used to hitch the shoulder.

Patient advice sheet ….

Although the pain of a frozen shoulder can be constant, the demands of life do not necessarily let up. At work you may spend a long time in the same position or perform some repetitive tasks. Here are some tips on how to get through the day with the least amount of discomfort:

• Avoid carrying heavy bags or cases for long distances; this has been demonstrated to precipitate tears in the supraspinatus, one of the important rotator cuff muscles

• If you are driving all day, or keeping your arm in a fixed position, take regular breaks where you can move your arm around to encourage circulation to muscles of the shoulder

• When working in front of the computer screen, take regular breaks. Get up and walk away from your work station and the PC for a couple of minutes every half an hour. This is important for the same reasons as above.

• Make sure your chair has good back support and preferably adjustable arm rests.

Adopt the 'ideal' work posture if you are sitting at a desk.

Patient advice sheet ….

Use it!!

Maybe that is the last thing you want to be doing when the arm is hurting, but it really will help long term! The only thing to avoid is the “catchy” type of pain that I am sure you are familiar with. Whatever you normally do with the arm, try to keep doing it as long as it is not too painful. Things like brushing your teeth, shampooing your hair or using your knife and fork. Although it may be difficult, these little things will help to keep the shoulder free and more mobile.

Patient advice sheet exercise ….

Spasm Exercise

- Rest the hand on a table or chair back palm up.
- Allow the weight of the arm to rest on the hand, causing slight compression at the shoulder joint. It is as though you were about to lean your body weight on your hand, while only applying a fraction of the force.

Breathe deeply and slowly. It helps to apply the pressure as you breathe out.

Patient advice sheet exercises

Repositioning the Shoulder

This is originally an Alexander Technique exercise which is excellent for resetting the shoulder position.

Do everyday if possible.

- Place a duvet or thick towel on the floor and lie on it, face up.
- Place pillows under both elbows and forearms.
- Rest the hands on your stomach, palm downwards (if that is not possible just rest the arms on the pillow).
- Stay in this position for twenty minutes. Try putting on some relaxing music.

Very slowly the muscles at the front of their chest should relax, allowing the shoulders to drop backwards, towards the floor.

You may not be able to get the hands flat for a while, but eventually you will. If necessary you can place a cushion on your abdomen and rest the hands there. Gradually try to lower this cushion to a few towels and eventually nothing.

When your shoulder has started to “defrost” in the second and third phase, you might be able to place the arms at 45º angle from the body. Turn the palms upwards if possible.

Patient advice sheet exercises

Shoulder Retraction

This is another exercise for resetting your shoulder position and posture. The good thing about this exercise is that it can be done everywhere, and does not require any equipment:

- Turn your hands palm outwards – slowly.
- Turn your hands palm outwards – slowly.
- Try to squeeze your shoulder blades together, automatically bringing your shoulders backwards.
- Keep your shoulders where they are but let the hands roll back into your sides.
- Hold that position for 30 seconds.
- Rest and repeat.

Patient advice sheet exercises

Swimming

As soon as the night pain is gone it is a good idea to get into the water. At first it may not look or feel like you are swimming, but do not despair; you are still doing your shoulder the world of good. The resistance of the water will help mobility and improve the strength of the shoulder.

- Try to go when it is quiet in the pool
- If you can't swim then simply walk up and down using your arms to help you
- Don't try to swim fifty laps; you are swimming to help your shoulder, not to win the Olympics
- Rest after every lap
- Vary the type of stroke you use after each lap
- Concentrate on trying to move the shoulder as much as possible rather than swimming fast or far
- Don't overdo it!! Easily done, stop well before you are tired or when the shoulder is hurting
- Water aerobics classes may also be useful so check if there is a class in your area.

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More info: Contact: www.triggerpointcentral.com

NielAsher.
Advanced Trigger Point Techniques

SH Hip

- Hey Mate,
- this is the raw footage slightly edited of a client who was booked in for a FAI hip surgery, he was referred to me via a a chiro collegue , classic ARI . He plays AFL footy, surfs and triathlete, suffering chronic insidous Bilat Lx spine pain , lateral hip/groin pain, hamstring tightness etc. Post 3/4 treatments all symptoms resoluted and the treatment your viewing was the maintenance treatment and applying the ARI principle.
- Principle :
- **Super TP** at Psoas lesser trochanter / Thoracolumbar T12/L1 junction , Hip extension restrictor
- **Super TP** at Adductor Magnus, Hip Abduction
- **Chase/Clear** passive internal rotation in hip flexion/ knee flexion.

SH hip

- https://drive.google.com/a/nielasher.com/file/d/0B9qKHy54SlSJVmpHaE9yNnBLWVU/view?pref=2&pli=1

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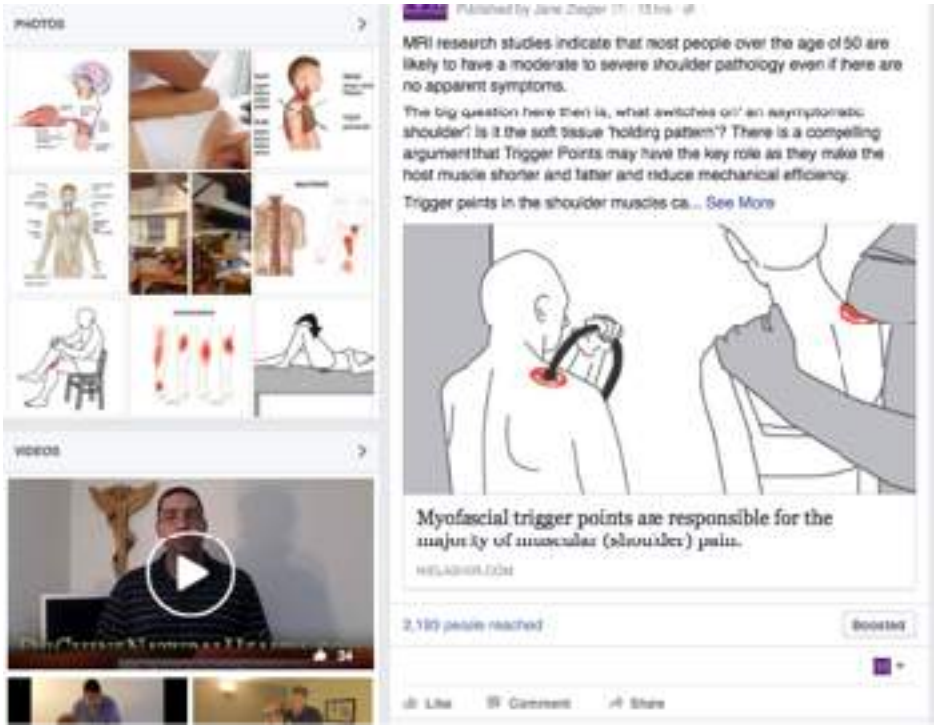

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