In Good Hands

The Newsletter of the Association of Massage Therapists (NSW) Ltd

March 2001

PRESIDENT'S REPORT

By Geof Naughton

Now that we have entered the new millennium, the AMT has a new captain on the bridge of the starship. My mission as Captain is not 'to boldly go where no man has gone before' (and I use the word "man" advisedly, as I am the first male President of the AMT!) but to consolidate the good work done thus far and extend our boundaries where I can.

For those members who don't know me, I graduated from the TAFE course in 1993 and I now have a clinic in Newtown. My background, prior to getting into the field of massage therapy, was in meteorology.

The Association has also enlisted a new person on the bridge in the form of a full-time Office Administrator, Mark Watchirs. His employment marks a shift away from having a number of part-timers filling the role. I hope this will lead to greater efficiency and continuity in the office - and I say this without denigrating the skills, application and effort of those who have worked in our Office previously. Mark has a varied background and comes to us having just completed a Certificate III in Business (Office Administration) at Ultimo TAFE.

I recently received a letter from one of our members asking, in effect, 'What is AMT doing for me?'. Let me take this opportunity to give you my thoughts on some of the services that AMT provides for members. The Association:

- provides a focal point for people in the same industry to meet and share common interests
- advances and protects the professional standards of its members
- advances and protects members' economic interests
- meets and counters threats to our profession from bodies such as Government departments and other industries

The AMT also provides its members with opportunities to establish or expand their business. We take out an advertisement in the Sydney Yellow Pages to allow members to be listed under the AMT logo if they choose to do so. Of course, this only applies to metropolitan Sydney … so we are also building a database on the AMT's website which covers the whole of New South Wales, region by region. For a small fee, AMT members can have their details listed in this database so that the Public can search for a qualified therapist anywhere in the state. Head Office also offers a referral service upon receiving inquiries from the public.

However, the AMT does not take members by the hand and promote everyone individually. Nor does the AMT get your CEUs for you. We can provide the ideas and opportunities, but you have to do the work! (Remember that attendance at the Annual Conference is all you need to meet a full year's quota of CEUs). The same applies if you want to upgrade your level of membership. The Association sets the standards and the criteria but, if you want to upgrade, you have to do the work.

There are also opportunities for members interested in participating in sporting events. Witness the wonderful stories by members involved in the Olympics, published in the last Newsletter. (If there is still any confusion about selection of therapists for the Olympics, let me clear this up once and for all: the AMT had **nothing** to do with the selection process - it was entirely the responsibility of SOCOG).

One topic which keeps cropping up in discussions between therapists is the distinction between **Diagnosis** and **Assessment**. *Functional Assessment in Massage Therapy* by Whitney Lowe contains a useful insight into this verbal minefield.

(Please turn to page 4 for the rest of Geof's report)

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NEWS FROM THE STATE COUNCILLORS

NORTHERN RIVERS Sharon Keogh

The support network was alive and well again in 2000, with therapists from Port Macquarie and Newcastle once again answering the call to volunteer for the 'Angel II Cycle Classic'. This is an annual fundraising ride for the Hunter Region's Rescue Helicopter. All the cyclists involved were extremely grateful for the hours put in by volunteer therapists. Thank you one and all.

On the 12th of August last year the first 'official' meeting of the Northern Rivers sub-branch was held. It was well attended, with 12 members and one non-member. Lyn Varcin-Coad, a physiotherapist on the Gold Coast presented a workshop on 'Lower Lumbar and Pelvic Pain', after the meeting. Lyn has lectured extensively throughout Australia, New Zealand and parts of China.

October saw the 'Hell on Wheels' cycle tour roll round again. This 9 day fundraising ride is for the Northern Region Rescue Helicopter. Christina Noordohf and I volunteered our services on days 3 and 7.

Rozena Secomb organised a workshop on 'Massage and Palliative Care' to coincide with Massage Therapy Awareness Week. The workshop was presented by Richard Holland who presented the 'Hospitals and Hospices' workshop at the Annual Conference in Sydney. The meeting was well attended with 4 members and 8 non-members, 3 of whom expressed interest in joining the AMT.

January this year once again gave us the opportunity to help with the 'Kayaking for Kemo Kids'. They are an amazing group of people and a pleasure to work with. I know they greatly appreciated the response from all the AMT members who gave their time.

The next meeting of the Northern Rivers Sub-Branch is on Saturday 28th of April at South Grafton Ex-Servicemen's Club, Wharf Street, South Grafton. The meeting will commence at 9.00am, followed by a workshop. We aim to finish at noon.

Well done to the Sydney crew on a great Annual Conference. Pearl and Russell Varcin, Christina Noordohf and yours truly represented the North Coast. The workshops were very informative, and interest has been expressed in luring Paul Doney, from the 'Working with Dentists' workshop, as a guest speaker for one of our meetings. We are eagerly awaiting our chance to host the conference too!

The Northern Rivers branch could also be involved in some fundraising for the AMT. I have been approached by the President of the Mongrel Bastards Mountain Bike Club (it's a long story!) to have the members of the club massaged for a fee, which would then be donated back to us.

The formation of our Northern Rivers sub branch has been extremely beneficial, not only for members in this region, but for the Association as a whole. Because we are so far removed from Head Office, it is difficult to attend workshops and meetings held in Sydney. Running our own workshops allows us to keep in touch with current trends and better serve the local community. It also gives outlying members a chance to meet and feel more a part of the bigger picture.

This year I will have the perfect opportunity to spread the word about our wonderful association - and hopefully sign up some new recruits! - while I undertake some of the units offered in the Diploma of Massage at Kingscliff TAFE.

On behalf of the Northern Rivers Branch, we hope you all had a Merry Christmas and a safe and Happy New Year.

ACT Malcolm Coulter

The ACT sub-branch has recently had a few changes in Office Bearers. I have taken over from Chris Howe as Branch Chairperson and June Jenion is now the Treasurer. Chris Howe and Theo Coulthard are committee members and Rob Carew continues as our sports massage co-ordinator.

I would like to thank Chris Howe for the work he has carried out for the AMT in this region. I wish him well in his Rolfing studies. Thanks also to Kirsten McCulloch, Paula Battersby, Kay Fredericks, Donna Povey and Rob Carew for their efforts.

The ACT was well represented at the Annual Conference. I personally enjoyed the event greatly and think it's fantastic to have the opportunity to network with so many fellow therapists. The venue was excellent and the TMJ workshop was a highlight.

I look forward to a busy year as chairperson and I will have a lot more to report in the next newsletter.

A MESSAGE FOR ALL RURAL & REGIONAL AMT MEMBERS

By Joel Morrell

Hi there! My name is Joel Morrell. I began the New Year facing up to the fact that I now have the job of being the Senior State Councillor. This position has been filled by many people over the years in many different ways, with styles that ranged from pedagogue to cattle dog. Well I can't be them – I can only be me. But I do want to start with something different. So instead of telling the Regional Area Leaders what they should be doing for you, I want to talk to you about what you, as individual members, can do for them.

And this will include the idea of becoming a Regional State Councillor. Now don't let yourself be put off by the high-falutin' name. The term 'Regional State Councillor' only came into being as part of the annual chance for regional people to have a day with the AMT Executive (and more importantly with each other) to talk about whatever was worrying them. Acting as 'State Councillor' means another trip to Sydney (apart from wherever the Annual Conference is held) and for some Area Leaders this is impractical.

I would also like to talk about how the different needs and locations can really alter how a particular region works. In the past most have grown (like topsy) around a major private massage school and/or a sizable regional town. Sometimes new groups have been established by a strong, committed local member. Frequently the School Principal or committed member has been the local motivator and then become a de facto Area Leader and State Councillor.

While these people make a very great contribution to AMT, when the time comes for them to move on, they can be a very hard act to follow. Maybe the answer for your area can be 'it takes two to tango'. In my early days I was greatly impressed by the Blue Mountains Area teamwork of Leonie Dale and Tamsin Rossiter but had great trouble knowing which was which. That is what I call real teamwork. Chris Howe and Kirsten McCulloch were doing much the same sort of thing in the ACT but this time I could tell who was who!

So now I am going to start asking the awkward questions. (You just knew I'd get around to it, didn't you?). Are you a State Councillor or Area Chairperson who is happy to stay on the job? *Please* let me know. Or would you like to step down? *Please* let me know. Are you a member who would like to have a go at Area Leadership? *Please* let me know. Are you a member who would like to help your local leader but don't know how? *Please* let me know. And *please* let me know your special interests, ideas and passions. Where do you think we should be going?

I had a very long and successful commercial career with a company whose philosophy was 'You are the Company. Not the managers, not the shareholders. Just you!' Well, **you** are the AMT. Without you, your area will disappear.

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LETTERS TO THE EDITOR

Dear Editor,

Thank you for sending me a copy of your Association's Newsletter Olympic Edition. It was interesting to read the comments of some of your members.

Physiotherapists and Massage Therapists worked closely together at many of the venues so I had the opportunity to observe the work of some of your members. The satisfaction of the clientele with the service provided was generally very high. I would agree with the comments in your newsletter that a lot of the credit for this belongs with Jeff Murray who I know put an enormous amount of effort into the planning of the Massage Therapy service. Jeff was a pleasure to work with both in the lead up to and during the Games. His deputy, Laurie Fawkner, deserves mention for his hard work as well.

Mark Brown
Executive Director, Australian Physiotherapy Association, NSW branch
Director of Physiotherapy, Sydney 2000 Games

Dear Editor,

I am writing to sing the praises of Rebecca Barnett's article "When two hands is barely enough". Perhaps it was the spacey feeling in my head after a session of yoga or the fact that I had just finished reading the poems a client had left for me to peruse, but I was totally enchanted by Rebecca's article. Mind you I learnt zip about **how** to massage a horse but far more importantly I was left with an overwhelming desire to go out and **do it**. And better still, I was encouraged to use my own intelligence and skills, to adapt and revel in the experience. Isn't that what massage is all about?

I haven't enjoyed reading an article that much in a long time. I hope we see more writing from Rebecca and by others with a similar love of prose. It was funny, stimulating and seductive. Would it be unethical of me to ask you for her phone number?

Paul Doney, Senior Level 3 member

PRESIDENT'S REPORT (CONTINUED)

"There is a distinct difference between assessment and diagnosis. A diagnosis is an assignment or label for an existing condition that is provided by a qualified health care provider such as a physician. Assessment is an ongoing process of information gathering that is used to help in making clinical decisions. As a massage practitioner, you will be using assessment skills throughout the duration of your treatment in order to determine if your approach is having a beneficial effect. A physician may use information gathered during assessment to make a diagnosis, but the process of assessment in and of itself is not a diagnosis. A massage practitioner will use assessment skills to evaluate the nature of his/her client's complaint and continually ensure that the current approach or method of treatment is the most effective for each individual." (page 3)

I find the internet to be a rich source of valuable information, assuming that it is from a reputable source. Two recent items have sparked my interest:

1. "Evaluation of the Patient with Shoulder Complaints" by Bruce C. Anderson, M.D. This article can be found at www.medscape.com. (This site offers a free weekly email newsletter on a variety of subjects aimed mainly at the medical profession but occasionally provides articles or links to items that do not involve drugs or surgery. I subscribe to the one on Orthopaedics).
2. "The role of mechanical and psychosocial factors in the onset of forearm pain: prospective population based study", published in the British Medical Journal, Vol 321, 16 Sep 2000. (www.bmj.com/bmj).

Although these articles target the medical profession, there is a lot of information that is useful to the massage therapist. If you have a patient with forearm pain who is not responding to treatment, then you will find the second article particularly interesting.

If you have any particular web site(s) you find useful/interesting, how about sharing them with the rest of us? Write, email or post the address on our bulletin board (if you haven't perused the bulletin board yet, please do so – just go to the AMT's home page and follow the online links. If you don't have net access at home, why not try your local library).

Don't forget that articles written for the Newsletter may be eligible for CEUs.

Geof Naughton

HOME STUDY MODULES

Gain your CEUs whilst studying at home! On application you will be sent a home study module applicable to your needs. There are two types of modules:

1. Multiple choice questions (mostly Anatomy and Physiology) at your level of membership. You can also challenge yourself by choosing harder modules. Each correct answer = 2 CEUs. All correct = 100 CEUs.
2. Short answer questions on Pathology taken from "A Massage Therapist's Guide to Pathology" by Werner and Benjamin (Williams and Wilkins). Answered correctly = 100 CEUs!

PLEASE TICK THE BOX(ES) FOR THE PROGRAMME(S) YOU REQUIRE

❑ A & P for General Level $55.00 ❑ A & P for Senior Level 1 $55.00

❑ A & P for Senior Level 2/3 $55.00 ❑ Pathology $55.00

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What's in a name?

By Mark Philip Deal **Senior Level 3 member**

If I said I was searching for a masseur or masseuse these days, most of us would think I was being politically incorrect. We all know that a practitioner utilising the art and science of Massage Therapy is called a 'Massage Therapist'.

But what happens when someone tells me they are a 'Myotherapist' or a 'Somatic Therapist' or that they practice PNF, MET, MFR or SLM? Are these people different from your regular Massage Therapist? Does the average person know the relative difference? Could you explain the differences to your clients if they asked?

And what about the specialties? There is Trigger Point Therapy, the Trager Method, Bowen Therapy, Reiki, Aromatherapy, Reflexology, Acupressure, Shiatsu, Kahuna Massage, Myofascial Release and Rolfing, just to name a few.

When I studied Chiropractic and Osteopathy a similar umbrella effect developed, particularly within the field of Chiropractic. There is Gonstead, SOT, Thompson Technique, Activator Method, Nimmo Practitioners and Applied Kinesiolology just to name a few. Many chiropractors began to take up a particular method to the exclusion of the others, even to the exclusion of techniques we were taught at the School of Chiropractic. Some even look down on those who perform techniques outside the range of their specialty. Because I practised techniques from varied sources and - god forbid! - massage, I was called a 'Diversified Chiropractor'.

Should Massage Therapy consolidate a little more so that we all know what each other is doing? Or should each of the extended disciplines be acknowledged in their own right? I would like to encourage members to comment on this issue and express your opinions. Moreover, I urge you to submit an article to this Newsletter on your particular forte or specialty so that we can all know a little more about the diversity within Massage Therapy.

At some stage Massage Therapy may undergo the transition into a 'Registered Profession', but it will need to standardise itself a lot more before this can be achieved. At present Acupuncture will probably be the next Registered Profession, with a set of standards required before a therapist can be registered as an Acupuncturist.

Does Massage Therapy as a profession want something like this? If so, then we all need a set of standards which must be met by a Massage Therapist before they can be Registered. Catherine Tiney has been working intensely with Government departments (on a voluntary basis) towards some standardisation for recognition of Massage Therapy as a profession. The Australian Traditional Medicine Society (ATMS) has been collaborating with its members for a similar set of standards to bring all members up to par with requirements.

The Association of Massage Therapists (your association!) has been working over the past few years on a standards basis for membership. Within these requirements is the concept of Continuing Education. Some of you have problems with this concept, but it seems that soon it will be a requirement of all associations.

All of us need to keep our skills honed and our knowledge up to date. "If you don't use it you lose it!".

The Association has a 'Distance Education' program which allows you to complete your Continuing Education Units at home (constructed by myself on a voluntary basis). This system makes it easier for you to upgrade your knowledge and meet the CEU requirement of the Association. Check with Head Office for details. (See advertisement opposite to order a home study module).

You could also check with the school where you gained your original qualifications to see if there are new subjects or distance education modules which may be recognised by the Association. Many schools grow with time and begin to incorporate different modalities, all of which could add to your skill as a therapist.

As the Principal of Peridor Health Schools I have recognised this need for continuing education within the profession. Peridor offers a range of courses in advanced training for Massage Therapists including Advanced Remedial Massage and Human Movement and Biomechanics. The detail in these courses is quite comprehensive but still falls under the banner of Massage Therapy.

Where possible I would like to see Massage Therapy both recognised as a distinct profession and for all modalities to be understood and embraced by knowledgeable, highly-skilled practitioners. There is still so much room to grow as a profession and as individual therapists.

ENHANCING EVERY SESSION – THE TRAGER® APPROACH

By Pauline Chester, B.Sc. Dip. Physiotherapy

How often have you finished a long day with clients and felt not only satisfied that your treatments have gone well but pleased that you are still full of energy? Many therapists are aware of the need for self-regulation – to look after our own bodies while we are treating others, to expend less energy and to finish our working day with feelings of ease and lightness.

The **Trager Approach** can help us achieve this.

How can we ensure that our clients also experience these sensations of ease and lightness? That they will also move freely, effortlessly and gracefully?

The Trager Approach teaches the therapist how to embody these qualities of ease and lightness, bringing them into our own movement throughout the day. Ease of movement improves our ability to take in sensory messages which, in turn, further improves movement and comfort for both the client and the therapist.

The Trager Approach is easy, effective and efficient, supporting the work of a busy practitioner.

Psychophysical Integration

Trager uses light, gentle, non-intrusive movements to facilitate the release of deep-seated physical and mental patterns which may develop as a result of poor posture, injuries, emotional trauma, stress and poor movement habits. It consists primarily of tablework and Mentastics exercises. Mentastics refers to simple movement sequences which increase body awareness.

Ten minutes of each Trager session is devoted to learning the Mentastics exercises. During the tablework, the practitioner rhythmically and gently guides the client through a series of movements which allow the client to achieve a deep state of relaxation. This process enables the client to remember what it is like to move freely and easily, with a full range of expression. These new sensations of movement then become new habits of movement.

The therapist's quality of touch is paramount, thus skilled massage therapists are in a good position to incorporate Tragerwork in their existing treatments.

Who can benefit from the Trager Approach?

Tragerwork has been used successfully with both acute/chronic soft tissue and musculoskeletal injuries, including sports injuries, arthritis, chronic lung problems, as well as pre and post-operatively. It has also been used effectively in the treatment of clients with neurological pathology, including stroke and Parkinson's disease. Healthy people can also benefit through improved posture, ease of movement and relaxation. Athletes can improve speed, endurance and performance. It is particularly useful for clients who might be considered "difficult": those who do not respond to our usual style of treatment or who have a lot of resistance or fear.

"Trager is the best complementary approach to my work. I now use Trager with many clients. After the training, I had an entirely new way of looking at the body."
Ann S., Massage Therapist

The Trager approach allows us to explore ways of expending less effort in our day, bringing a new ease into our lives. For individual sessions and/or an introductory workshop in April please contact
Pauline Chester on (02) 93277034.

AMT ANNUAL CONFERENCE 2000

The AMT Annual Conference for 2000 'Bridging the Gap' was held in Sydney at the Harold Park Racing Club, Sydney. Members from all over the State made the trek to Sydney, enjoying two days of high quality workshops and lectures. Paul Doney's workshop on TMJ dysfunction proved to be a real crowd pleaser but all four workshops were extremely well-received. Joel Morrell, who presented the workshop on Fibromyalgia, was inundated with requests for transcripts from his session. He has graciously agreed to publish his lecture as a series in this newsletter. You will find the first instalment on page 10.

Matt Dilosa *submitted this review of the Opening Address the conference.*

The opening address at the 11th Annual AMT Conference was given by Nicolas Stepkovitch, Director of Physiotherapy, Mt Wilga Private Hospital, Hornsby, NSW.

The theme of the weekend was **Massage: Bridging the Gap** and Nicholas' address certainly emphasised this ideal. I suspect that most attendees would not have been aware of the rich and distinguished history of massage, myself included.

Nicolas provided the audience with an understanding of where massage therapy currently sits within the complementary health field and he outlined the progress of government legislation regarding competency standards of massage therapists nationally. He suggested strategies to meet these challenges and more effectively work towards mainstream integration.

Currently there is a wide variety of massage courses taught by different institutions. These include TAFE and private colleges, with courses which range from one semester to two years in duration. There are no national competency standards in the teaching of Therapeutic Massage and no regulatory criteria, so at present anyone who has completed a course, whether it be one weekend or three years, can put up a shingle and call themselves a 'Massage Therapist'.

Nicolas gave some examples of how the lack of uniform criteria has impacted on massage therapists. He quoted the Director of Massage services for the Olympic Games, Jeff Murray, whose task was to select 400 therapists with appropriate qualifications and experience. The applications covered some 18 square metres of floor space but six months into the process Jeff was no closer to making a final cull. In an article for 'Sport Health', the official magazine of Sports Medicine Australia, Jeff wrote:

Unfortunately I realised that massage therapists do not have set qualifications and/or standards. Unlike our counterparts – doctors, physiotherapists, chiropractors and osteopaths - all of whom study at a university and whose qualifications are recognised state wide, if not nation-wide, massage therapists have no standards at present. There is nothing to benchmark off. Each massage association considers their therapists to have the best qualifications. There is no standardisation.
Sport Health, Vol 18 No 2, Sept 2000 pp. 17-18.
[SMA]

Most members of the AMT would be aware that the first National Competency Standards for Massage Therapy have been drafted - the Certificate Level III in Sport (Massage Therapy) and The Diploma in Sport (Massage Therapy). The underlying emphasis behind this reform is on clinical reasoning, an issue that affects all health professions.

Nicolas stated that *the concept of a national standard is being driven by bodies other than Massage Therapy groups and largely due to the increasing demand in the sporting arena, obviously enhanced by the Olympic catalyst.*

Our industry must embrace the concept of a National focus, forum or representative body to take full advantage of the current situation and place massage therapy in the most effective position to be recognised as a competent and accountable branch of the allied health professions.

He went on to say that this process will no doubt take time and there will always be individuals who will stand in the way of the entire industry becoming more professional. It is up to us as a profession to surmount those obstacles and become better health practitioners.

Massage Therapists want to work more closely with the existing professions and the one consistent avenue for acceptance and co-operation amongst professions and payers is accountability. This is achieved by the production of outcomes. Many of these professions are having to come to terms with the efficacy of their treatment interventions, both in cost and outcomes.

What we can do right now is measure the success of our treatment /intervention. This measure need not be done at any great expense, but more as a matter of discipline and practice efficiency. Measures of outcome have recently been outlined by Compensible bodies in NSW. The Workcover Authority and the Motor Accidents Authority of NSW have recently run symposiums on this issue.

What they want to see is three accepted measures of outcome in all cases. These are:

1. **Pain rating**. The Visual Analogue Scale [**VAS**: 1-10] is the one most generally accepted.
2. **Range Of Movement [ROM**] There are various recognised methods of measurement. Some examples are Straight Leg Raise (SLR) measured in degrees with a goniometer, Cervical Rotation: chin midline to AC joint in centremetres using a tape measure, and shoulder elevation and abduction using a goniometer.
3. **Functional Component**: The patient initially reports an **A**ctivity that they cannot perform effectively as part of their **D**aily **L**iving [**ADL**} or work. This can be hanging out the washing, turning their head to reverse a car, sitting for over fifteen minutes without pain or being able to play a game of tennis without physical handicap, whether it be at a social or international level.

These measures must provide proven efficacy of the treatment or intervention involved. It will not matter from what discipline a practitioner originates. All practitioners will need to provide a definitive outcome of that intervention, whether it be by improvement of a disability or prevention of injury and/or recurrence. Ultimately our clients and the relevant insurance bodies will want the most effective and cost efficient outcome currently available.

In summary, Nicolas' message to the massage profession was 'bite the bullet' and embrace the establishment of competency standards and evidence based practice through research and outcome measures. This is the only way forward if we want to gain full acceptance and integration into the mainstream health care delivery system. Once Massage Therapy demonstrates a commitment to developing a standardised and accountable professional body using methods with a proven efficacy, then acceptance by the mainstream medical model must follow.

I must admit I was a little defensive when Nicolas opened his address, but he spoke with enthusiasm and passion for quality health care delivery and was encouraging in all his words. I for one will be taking up the challenge.

AWARDS

Massage Therapist f the Year

Tamsin Rossiter

Award of Excellence

Marimil Lobregat

Robin Hill Student Therapist of the Year

Brett Higgins

Peter Stratton Student Therapist of the Year

Brendan Byrne

FIBROMYALGIA SYNDROME AND ASSOCIATED PROBLEMS

AN OVERVIEW

By Joel Morrell

At the recent AMT Annual Conference I somewhat foolishly committed myself to reworking the content of my workshop on Fibromyalgia for publication in this newsletter. I have realised now that what one can say with vehemence and passion in a workshop environment, is much more likely to be considered inflammatory and inappropriate in cold irretrievable print. Hence, as a remedy, this is the first of a series of articles which will discuss various aspects of Fibromyalgic Problems in (hopefully!) an objective and even handed manner.

The first problem is with the word **Fibromyalgia**. Let's break it up to see what it means. FIBRO-MY-ALGIA simply means Muscle Fibre Pain. When the word is used standing alone without descriptive qualification it is as non-specific as the word headache. Whenever I hear someone use the phrase 'all the Fibromyalgias' then I think that the speaker has not even scratched the surface of understanding the problems.

My workshop was really about Chronic Fibromyalgia Syndrome. This is a clearly defined medical syndrome with Diagnostic Criteria so let us look at the definition. For long term problems the **American College of Rheumatology** has adopted a detailed definition for **Fibromyalgia Syndrome.** Key factors include:

1. duration in excess of three months
2. pain persisting in all four quadrants (both sides of the body and above and below the waist)
3. elicitation of a minimum number of specified **Tender Points**.

Other key factors are:

4. sleep disruption especially non R.E.M. sleep
5. a related reactive depression.

It should be noted that Chronic Fibromyalgia Syndrome is not Chronic Fatigue Syndrome which has its own definition (we will address this in a later article). In Fibromyalgia Syndrome other symptoms may include fatigue, either persistent or recurrent, but in Chronic Fatigue Syndrome, it is fatigue that predominates and is often unremitting. The true **Tender Points** are not common either. Chronic Fatigue sufferers can experience intermittent labile Fibromyalgic periods but pain is a secondary feature. In Fibromyalgia Syndrome, the sufferer's pain predominates and fatigue is intermittent or even absent. It should also be noted that Chronic Fibromyalgia Syndrome is not the same as Chronic Myofascial Pain Syndrome, which also will be the subject of a later article.

In addition Fibromyalgia Syndrome can vary greatly according to its aetiology. Post-traumatic Fibromyalgia, whether from industrial or traffic accident, or from medical crisis or social grief crisis, is a completely different issue which can be distinguished from true idiopathic or familial Fibromyalgia Syndrome.

So why is Fibromyalgia Syndrome a source of such controversy and confusion? I would like to spend a few moments examining the conceptual gap between Wellness, Illness and Disease. The quandary lies in a tangible versus an abstract. Gertrude Stein may well have written 'A disease is a disease is a disease'. For a disease is 'pathology' that can be demonstrated, proven and understood.

But what is illness? It is a void, an absence of something. How do you demonstrate or understand an absence of something, especially when it is an absence of something as hard to define as Wellness or even Health? The quandary for a traditionally trained general practitioner is that disease is assessed objectively, with signs and symptoms, and then confirmed with x-rays and Pathology tests. Disease is **provable scientifically**. However, **illness** is something that has to be assessed only on your hearing of what the subject tells you that they are experiencing. Thus it is highly subjective. Regrettably for many doctors 'highly subjective' means 'highly suspect'. The result for many doctors? … 'illness' is a pain in the bum.

The great quandary of Fibromyalgia Syndrome is that it is an illness that includes chronic severe pain and marked disability but without demonstrable pathological tissue changes. Further, it is in the 'disease sense' non-progressive. While symptoms may increase over time, idiopathic Fibromyalgia Syndrome does not of itself lead to other diseases such as Arthritis or Rheumatic Fever and is not associated with skeletal degeneration.

Primary Idiopathic Fibromyalgia Syndrome was for centuries described as Primary Rheumatism. From early in the 20th Century until around 1980 the term Fibrositis was substituted. Now this is out of favour and the new term of Fibromyalgia is causing people to rant and rave about the emergence of some new strange 'outbreak of alarm'. Be assured that Rheumatic/Fibrotic/Fibromyalgia was described by Hippocrates some 2,400 years ago. I hope you will enjoy sifting through some of the facts and fictions about Fibromyalgia over the coming issues of the AMT Newsletter.

If you would like to join the Fibromyalgia Study Group please feel free to contact me at:
6 Doyle Lane, Nambucca Heads, NSW 2448
Telephone (02) 6568 8333 Email arn@tsn.cc

HEALTH FUND STATUS

Health Funds and Societies	Status
ACA Health Benefits Fund (SDA Church)	1
AXA Australia Health Insurance	2
Commonwealth Bank Health Society	1
Gay and Lesbian Health Fund	2
Geelong Medical Benefits Fund	2
Government Employees Health Fund	2
Grand United Friendly Society	2
HCF	2
Independent Order of Oddfellows	1
Independent Order of Rechabites (IOR) Health Benefits	1
Manchester Unity	1A
MBF	3
National Mutual Health Fund	2
NRMA Health	2
NSW Teachers Federation Health Society	1
Queensland Country Health	1
Railway and Transport Hospital Fund	1
Reserve Bank Health Society	1
Victorian Workcover Authority	2
Westfund Health Fund	1

Status 1: All financial practitioner levels.
Status 1A: All financial practitioner levels with:
- One million dollars current insurance
- Current First Aid

Status 2: Senior Level 1, 2 and 3 members with:
- One million dollars current insurance
- Current First Aid

Status 3: As above. Must have sent a copy of a receipt to Head Office for verification.

- Members must be **financial** and have a commitment to ongoing education (average of 100 CEUs per year).
- Clients must be provided with a formal receipt clearly indicating the practitioner's name, AMT member number, practice address (no PO boxes), phone number, client's name, date of treatment and nature of treatment (i.e. remedial massage treatment).
- All health funds require our members' practice address. When you receive your next renewal form you will be asked to provide your practice or business address (no PO boxes). Failure to do so will result in your name being removed from the health fund listing.
- Please send a copy of one of your receipts to Head Office with your renewal form.
- Professional receipt books with the AMT logo are available from head Office for $15.00.

HIGHLY STRUNG AND OUT OF TUNE

A Clinical Perspective On Guitarists

By Pat Curley Senior Level 2 member

Much has been written about the benefits of massage therapy for athletes. The field of sports medicine has become a speciality that many AMT members excel at. The literature is abundant and there is plenty of opportunity to learn and practise massage as it relates to all types of sport.

Sports massage applies various therapeutic and remedial techniques to the specific needs of the athlete, depending on the demands of the sport at different stages of training and competition. Once trained in these techniques, the sports massage therapist must take into account the dynamics of the particular sport as well as the functional anatomy involved and develop appropriate assessment tools and treatment options in accordance with these factors.

This is an approach we all use to some degree in clinic whether it be on elite athletes or your average Joe. Many people present with pain caused by habitual overuse patterns. I'm a musician and recognised long ago the stresses and strains of endless hours of single-minded practise. Musicians often place unhealthy (and unholy!) demands on their too-often frail frames, but they rarely have an athlete's awareness of the importance of training and fitness. As a result they very often suffer for their art (and I suspect secretly enjoy it).

When I accepted that my days as a professional musician were numbered and began to eke out a career in massage therapy, I became aware of what all those years of practise had done to my frail frame and - more importantly - that something could be done about it. I analysed my (guitar) playing posture, related that to my own neck and shoulder problems and then sought appropriate treatment and corrective exercise. After completing this personal assessment I wanted to find out what other guitarists had subjected themselves to.

I enlisted the help of guitarists in Lismore, studying for the Bachelor of Contemporary Music at Southern Cross University. When the head lecturer of the programme asked a group of about 40 guitarists, mostly aged between 18 and 25, how many had physical pain related to their playing all but 3 raised their hand. I studied about 30 people over 9 months. It was never my intention to do a tightly controlled clinical trial and there were gaps in my research methodologies, but I did learn a few things.

From the information gained I have developed a program, specifically for guitarists, that addresses some of the postural problems inherent in playing the instrument. It aims to find a playing position that is least problematic, allows maximum relaxation and in no way compromises the technical facility of the instrument. To do this I use Tai Chi and Qigong principles because they teach movement with efficient posture and maximum relaxation. While these help significantly some problems remain.

The second part of the program aims at managing these problems. This is the part that I hope is of interest to massage therapists, examining how overuse patterns can cause postural dysfunction and pain. For the sake of clarity we will assume that our subject is right-handed.

Postural Analysis

Most guitarists tend to sit when they practise. This can be either cross legged, which rotates the right innominate and causes problems in the sacrum and lumbar spine, or with both Ilium flat on the chair, the legs slightly abducted and the guitar resting on the right thigh. In this position there is considerable rotation to the right in the lumbar and low to mid thoracic vertebrae. Classical guitarists sit straight with the left knee raised, the guitar on the left thigh and some spinal rotation to the left.

The left arm usually hangs comfortably from the shoulder with the elbow flexed and tucked into the body at the waist. If there is excessive spinal rotation to the right, the left arm will have to reach further forward to grab the neck (of the guitar that is, not their own!). This problem can be addressed with changes to playing position. However, it is impossible to negate the protraction of the scapula and medial rotation of the shoulder joint on the right side, particularly with larger acoustic guitars.

Guitarists pick the strings either with a plectrum or their fingers. Fingerpickers have their wrist in a fully flexed position, while flatpickers (who hold a plectrum between the thumb and forefinger) have their wrist in a neutral position and pick with either small ulnar and radial deviations of the wrist or flexion/extension of the thumb and forefinger, or a combination of the two.

It is important that the wrist is loose and comfortable. If it is stiff there will be tightness in the muscles of the forearm and too much flexion and extension of the elbow. Because the shoulder is also extended, this up and down movement of the hand requires rotation of the shoulder. When the wrist is fixed these movements will be short and quick and, as a result, the shoulder rotators eventually develop too many fast twitch fibres and they fatigue very easily.

The other common problem is in the neck (of the guitarist and not the guitar!). There is a tendency to protrude and extend the neck to look down at the instrument. This causes a forward head posture which is a common problem in most of our clients with neck pain.

The alternative is to stand up and play, which is better but can produce the classic sway back posture as the guitarist pushes the pelvis forward and looks down to see what the hands are doing. There is also usually some spinal rotation to the left, because the guitar falls off the strap closer to a coronal plane, and the left shoulder is dragged back.

Functional Anatomy

The three main problem areas are the neck, shoulder and lumbosacral area. In this study, those with lumbosacral pain usually had short and/or weak hip flexors and/or rotators. If the player tended to sit low with the knee higher than the pelvis then the hip flexors were invariably short. If he or she sat with both ilium flat on the chair the rotation showed up in the lumbar and thoracic spine and the deep spinal rotators on the right were short from overuse.

Many guitarists look down at the fingers as they play, resulting in a forward head posture. Short neck flexors were the main culprit. Normally as the neck flexors shorten, the posterior neck muscles on the occiput: (upper traps, splenius capitis etc) also shorten to tilt the head up so the eyes look straight ahead. Even if the guitarist does not constantly gaze into their abdomen, the posterior neck muscles are still subject to tension. The problem is made worse when they do look down to play and these short muscles have to lengthen and hold the head up. They fatigue pretty quickly.

These scenarios for neck tension are common ones that most of us encounter in our clinic every day. Many of the subjects I studied may have encountered these problems even if they didn't play the guitar.

The interesting part of this study was learning what happened to the shoulder and arms, particularly on the right side. The combination of scapula protraction and medial rotation of the shoulder places a lot of stress on the muscles that stabilise the scapula anteriorly: pectoralis minor; coracobrachialis and the short head of the biceps brachii. Palpation at the coracoid process produced tenderness in 100 percent of cases. As these muscles shorten they pull the scapula down anteriorly so that it wings at the back with the inferior angle protruding. This in turn places an excess load on the teres muscles, they shorten locking the scapula further and the rhomboids become underused as they are not required to stabilise the scapula during normal shoulder movements. The scapula moves laterally and the shoulder protrudes even further. (For a fuller description of this pattern check out Schultz and Feitis, *The endless web: Fascial Anatomy and Physical Reality* pp 87-89). During playing the weak rhomboids are called on to stabilise the scapula as it moves further forward but they are ischaemic and easily fatigued. This was a common area of pain and in many cases significantly restricted the guitarists capacity to play. A number of subjects also had vertebral facet joint dysfunction and rotation of individual segments in the mid to upper thoracic. This may have been caused by the rotational forces in the spine or other unrelated factors but the rhomboid problems would have exacerbated this dysfunction.

The other common problems occur in the wrist and elbow caused by overuse of the wrist and finger extensors and flexors. Fingerpickers combine isometric contractions of the wrist flexors and extensors with precise, rapid movements of the fingers.

A Clinical Perspective On Guitarists

Flatpickers rely more on ulnar and radial deviation so produce rapid contraction and relaxation of the wrist flexors and extensors. If the wrist stiffens they rely more on the elbow flexors/extensors and shoulder rotators.

Treatment Options

Initially I did not treat any of the subjects in the study. I prescribed stretching and strengthening exercises as appropriate and demonstrated some self-massage techniques. Using tennis balls, I demonstrated a number of simple cross fibre and longitudinal strokes they could do by working the tennis ball in under the clavicle and on to the chest to release pec minor and leaning against a wall to release the rhomboids. These combined with sustained, relaxed stretches effectively addressed shoulder problems. In many cases pec stretches were enough to relieve most rhomboid pain.

Stretching was also effective for low back pain, focusing on hip flexors, hip rotators and hamstrings. Cross fibre frictions and longitudinal gliding were prescribed as self massage on the forearms and this improved both wrist and elbow pain considerably. Chin tucks were prescribed for neck problems. Only two of the most chronic cases decided to have treatment and these proved to be effective too. After a few treatments they were able to stay pain free using these stretches and incorporating some changes to playing posture.

These treatments presume that the playing posture is as efficient as possible. Unless you are treating a classical guitarist get the player to stand while they are practising or alternatively sit on a stool with the guitar on a strap and the spine straight. The focus of the relaxation exercises is to ensure an open and relaxed chest to take the strain away particularly from the pec minor.

Apart from these simple things I did not find anything inherently wrong with an efficient playing technique that could not be resolved by the sort of assessment and treatment options we use daily in our clinics. If you are treating a musician ask if they have received good tuition.

Another important consideration, particularly with the serious student of the instrument, is attitude. S/he will identify themselves as being 'a guitarist' and equate their ability to play with their self-worth. They will sit for hours, losing track of time, and dedicate their life to becoming a better player. It becomes their holy grail and the ultimate goal is at stake with every note they play. Combine this intensity with excessive neuromuscular activity and the type of postural dysfunctions that can result, and the way out can be very difficult indeed.

I am developing a book which outlines the whole program in detail. If you would like further information please call me on (02) 66225072 or (02) 66224851. Email: curley@turboweb.net.au

ARE YOU LIVING AND/OR WORKING IN ISOLATION FROM OTHER MEMBERS?

Let me first apologise for the smart alecky title I used before - THE REALLY LONELY HEARTS CLUB. I have been told in no uncertain terms that this was the cause of many members **not reading** my message. To date only two members have responded so let me just repeat the story under this more accurate and respectable banner.

For many years the AMT has featured local support groups, notably New England first led by Valerie Jenkins, Canberra by Sandra Morgan, the Riverina by Tuesday Browell and Newcastle by Alan Kitchen.

On the North Coast Joel Morrell has had first hand experience of what it feels like to be the only kid on the block. Now that this area has been divided into two regions with Janet Crombie looking after the Mid North Coast and Sharon Keogh looking after the Northern Rivers, Joel is turning his attention further afield.

We have in mind a special Professional Fellowship Group either by correspondence or by e-mail for those members whose physical practice or home location places them out of reach of normal branch activities. If you fit into this category and would like to take part then contact Joel Morrell either at:

Address: 6 Doyle Lane Nambucca Heads NSW 2448
E-mail: arn@tsn.cc
Phone: (02) 6568 8333.

In Memoriam

The AMT (Mackay branch) has lost one of its strongest members. Don Russell passed away on December 26th, 2000.

Don will be remembered as a keen supporter of the Mackay Branch. He served for 2 years on the Executive Committee.

Don was the first to arrive at every meeting and the last to leave. It was thanks to Don that we had so many photos in the newsletter as he was our official photographer.

He had a special interest in sports massage and was still studying his beloved Anatomy and Physiology right to the end of his life, despite the discomfort of his illness.

Don was a gentle person who lived by his principles. He had a warm heart and gave out a lot of love and respect.

He will be sadly missed by many people.

Valerie Jenkins
Rod Legge
Linda Danvers

DEEP VEIN THROMBOSIS:
Why It's Not Just The Airlines Who Should Be Nervous

By Rebecca Barnett

Unless you have been suffering from a terminal New Year's hangover, have your head in a bucket or been holed up in the remote and sleepy town of Burrumbuttock, you would have noticed the media frenzy over Deep Vein Thrombosis (DVT).

It has dominated the headlines of all the major news services and become a favourite topic of discussion amongst … well … just about everyone. DVT caused by cramped conditions on long haul flights is just more grist for the mill of the current affairs programmes. And it seems entirely possible that some of the large airlines are going to have their Fokkers sued off.

But what has all this got to do with massage therapy I hear you ask? What is this thing called Deep Vein Thrombosis? And why should we be nervous?

Definition

Deep Vein Thrombosis refers to the formation of a thrombus (blood clot) within a deep vein, usually in the thigh or calf. This clot can either partially or completely block the flow of blood in the vein.

This means that if a client hobbles into your clinic complaining of calf pain and you proceed to hoe into the gastrocnemius you may well be providing the necessary impetus for a clot to break free, if it turns out that the pain was not actually muscular in origin but circulatory. And where does this travelling clot (embolus) head for? It's on an express train to the lungs, arriving punctually at Pulmonary Embolism (PE) which is a less than salubrious place. In fact, it's so unsalubrious it can be fatal.

What Causes DVT And Who Is At Risk?

We are now all aware of the risks involved in long periods of immobility but what are the other risk factors for developing DVT?

- some people have a genetic predisposition, which remains subclinical until an additional stress occurs (e.g. immobilisation for long periods)
- physical trauma can damage venous tissue creating a need for the body to respond with blood clotting. Think athletes and sports people (i.e. it can happen to extremely fit and healthy people)
- complications of surgery and radiation therapy. Thrombosis and subsequent PE is the leading cause of death following orthopaedic surgery, particularly for knee and hip replacements
- Poor circulation from inactivity, prolonged bed rest or conditions such as varicose veins
- Pregnancy, where the weight of the foetus on the iliac veins and inferior vena cava slows venous return and increases the risk of clot formation. Additionally, there is a tendency in the later stages of pregnancy for the blood to form clots to prevent excessive bleeding during childbirth
- Local infection, severe systemic infection, liver disease and some cancers
- High oestrogen birth control pills.

The chances are that you will encounter someone with DVT at some point in your career. If the client is unaware of the condition and you have not done your homework properly, the consequences could be grave.

A Personal Anecdote

Some years ago I crawled into the casualty ward at Royal North Shore Hospital with severe abdominal pain. I was unlucky enough to encounter a triage sister who graduated from the Adolf Hitler School of Empathy Building. While I did a passable impersonation of the green goo scene from The Exorcist, she asked officiously if I could hyperventilate more quietly. The Price is Right was blaring from a television in the corner. It didn't ease my suffering in the slightest.

But hang on, what does bad afternoon television and abdominal pain have to do with DVT I hear you ask? Well, I'll get to that bit eventually. In the meantime just accept that I may well have a relevance problem.

After what seemed like an eternity of bodily fluid break dancing on hospital lino, I was admitted to casualty. Seven hours, a battery of tests and 20 milligrams of morphine later I floated up to the theatres for a laparoscopy (STAT!).

Now a hospital visit is one of the least glamorous experiences of a lifetime: shapeless white gowns which expose an alluring bit of crack at the merest opportunity, the distinct pallor of ill health, the acrid smell of sweat and bile. So I was most amused when, no sooner was I wheeled into an operating theatre, a surgical orderly proceeded to lovingly roll a pair of white stockings onto my legs.
"I'm sure that won't be necessary," I mumbled in my haze, recalling gratefully that at least the days of shaving from the neck down were over. "I don't suppose you have something more flattering … perhaps in dark blue."

Shortly after that, I was plunged into blackness. It turns out that my appendix had erupted and filled my enteric cavity with large volumes of pus which the surgeon vacuumed out. It doesn't get much less glamorous than that, I can assure you.

DEEP VEIN THROMBOSIS

But I can sense that your impatience is growing. What in God's name does all this have to do with DVT? Okay, okay … I'll get there in a minute.

Every morning for the rest of my mercifully brief hospital stay, the surgeon came to check on my progress. He asked a lot more questions about pain in my legs than pain in my newly-zippered abdomen. This confused me unutterably at the time. He would also squeeze my legs in a manner that I would consider waaaaay too familiar if it weren't for the fact that he was a close colleague and friend of my father's. There was much rejoicing the first time I got up to answer the call of nature, even though I walked as if I had spent three continuous years in the saddle. A student nurse administered her first ever injection using my stomach as her test site. It was an anti-coagulant drug called Heparin and I was happy to provide the occasion for such a defining moment in her fledgling nursing career.

It wasn't until I was safely home and unanaesthetised that it finally occurred to me what this elaborate ritual was all about. Of course. It all made perfect sense: the white stockings, the questions about leg pain, the squeezing, the Heparin, the joy at my first tenuous ambulations – I was at risk of developing post-operative DVT. (Phew! I knew that we would get to the point eventually!). Even though I was reasonably fit and healthy before my ordeal – I had just returned from the Middle East where I had averaged 40 kilometres of walking a week – I was still a prime candidate for DVT because I had undergone surgery.

What Are The Common Symptoms Of DVT?

The most common signs and symptoms include:

- A 'pulling' sensation at the insertion of the calf muscles into the posterior portion of the lower leg
- tenderness or pain in the affected area of one limb
- oedema (swelling) usually in the calf or medial thigh (in areas drained by the vein where the blood clot is located). This oedema may be classified as "pitting oedema" if a hollow pit remains after you have applied thumb pressure to a part of the limb.
- redness, discolouration or warmth over the path of a deep vein
- fever (if the DVT is caused by a local infection)
- a vein that feels like a hard cord or piece of rope

It is important to note that often DVT is asymptomatic (ie totally without any symptoms). It is possible that the only indication will be a deep ache in the affected area. This should always ring alarm bells for the massage therapist.

How Do We Proceed?

If you suspect that a client may indeed have DVT, one way of testing this suspicion is to passively dorsiflex their foot. If the client feels sharp pain this could indicate the presence of a clot in the leg. (This is called the Homan's sign). Obviously, some kind of mechanical/muscular problem could also cause pain on passive dorsiflexion but referral to a GP to allay any fears is a painless alternative to a medical negligence suit.

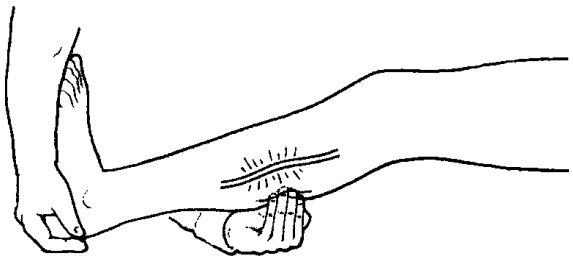
Homan's Sign - Test for Deep Vein Thrombosis

This test is used to aid in diagnosis of DVT. Pain in the calf is considered a positive Homan's sign.

- the client is supine on the table with the knee extended (remove the pillow if necessary)
- slowly and gently (passively) dorsiflex the foot and add some overpressure
- pain at the back of the knee or in the calf indicates a positive Homan's Sign

Other signs that may be present:

- tenderness on palpation, pain on stretch
- pallor
- swelling (oedema) and an increase in the circumference of the area
- warmth



clients rang me in the middle of the media blitz on DVT to book an appointment. She had suffered a serious fall in a shopping centre and undergone knee reconstruction. It was now two months down the track and she informed me that she was getting pain in her calf as a result of the reconstruction and that she wanted me to massage it. On further questioning it transpired that she had post-surgical complications and had ended up back in hospital a month after the operation. The problem? … you guessed it – DVT.

So here is the scenario in a nutshell: a client with diagnosed DVT asks me to massage her leg to work out the post-operative pain. Well, I took a deep breath and explained why there was no way I would go anywhere

near her legs. After ten minutes of detailed and insistent explanation, she replied "Yes, my specialist told me that I was not to allow anyone to massage my legs". I was completely gobsmacked by this admission. However, it taught me a valuable lesson: never underestimate your client's ability to ignore or openly defy the instructions of their doctor/specialist, even though the risks involved in doing so have been thoroughly explained.

I informed my client that I would not massage her legs until I had a letter of clearance from her specialist. Last time I spoke to her, she had been taken off anti-coagulant medication and was well on the way to resolving the DVT. I just hope she wasn't contemplating any long haul plane flights.

A Piece Of Verse To Finish

I have taken the liberty of composing a brief poem on the subject of DVT, using the Japanese 5-7-5 syllable verse form known as the Haiku. I hope you find the experience of reading it as enlightening as I found the process of writing it!

Danger Will Robinson: A DVT Haiku

If your client says
"My calf hurts, please massage it
vigorously now"

Do not cross fibre!
Do not prod with all your might!
Proceed with caution.

This is serious.
Think "Danger Will Robinson"
Do not flail your arms.

Deep vein thrombosis
Could be the cause of the pain
Rather than muscle.

Dorsiflex the foot:
If your client feels sharp pain
Do not touch their legs

with a forty foot
barge pole (that is twelve metres
speaking metrically)

Carefully explain
the contraindications.
Tell them your concerns.

Immediately
refer them to their GP
for tests and clearance.

Have a cup of tea.
Put your feet up on the lounge …
BUT NOT FOR TOO LONG!

Are You A Professional Massage Therapist Or A Wandering Clot?

By Diana Glazer Senior Level 2 member
FIR, Grad Dip Sci.Med (PM)

The body is a miracle of checks and balances that continually work towards homeostasis and repair. One such miracle is haemostasis – the prevention of blood loss by the formation of a blood clot within the blood vessel or a crust on the skin surface.

Normally platelets flow freely through the blood stream but under certain conditions (for example after a fracture, immobility, certain drugs and obesity) they will stick to the surface of the vein, to each other and to other blood cells creating a soft blood clot that blocks the flow of venous blood. The resulting solid gel is called a **thrombus**. If it breaks off and moves to circulate within the bloodstream it becomes an **embolus** – a wandering clot.

The embolus will continue to travel within the blood stream until it is stopped by a blood vessel whose diameter is so small that the clot can go no further.

Imagine that a client comes to you complaining of deep calf pain and swelling after exercise a few days ago. You know from previous experience that this client does not stretch before undertaking exercise so you immediately assume low grade tearing of muscle fibres causing swelling, pain and discomfort and a limp which assists in shortening the gastrocnemius. You start your routine with moderately deep effleurage in preparation for deeper work to bring more blood and nutrients to the injury, to align new fibre formation and to reduce spasm in the rest of the muscle.

Differential diagnoses for this scenario include superficial vein thrombophlebitis, cellulitis, ruptured muscle or tendon, muscle strain or severe muscle cramp, ruptured popliteal (Baker') cyst, cutaneous vasculitis and lymphedema.

But what if this client actually has thrombosis in the deep veins of his gastrocnemius?

Effleurage may move the clot or break part a part of it allowing it to travel through the deep veins of the gastrocnemius, up the femoral and iliac veins, through the inferior vena cava and into the right atrium. From there it will move to the right ventricle and onto the pulmonary artery. The lungs are the only destination for venous emboli formed anywhere in the systemic circulation. Once lodged in the lungs the clot becomes a pulmonary emboli (PE).

Where the clot stops and how much damage it does depends on its size. Small emboli will travel further into smaller and smaller pulmonary branches and will eventually lodge in a small branch resulting in a small amount of lung damage. Large emboli will block a much larger pulmonary trunk denying oxygen to a large part of the lung. Smaller pulmonary emboli cause pain, shortness of breath and coughing up of blood, large PE can cause sharp chest pain, unexplained coughing and death.

Alarm bells should ring if:

- during history taking the patient mentions taking drugs such as heparin, warfarin and aspirin for blood thinning or the fibrinolytic enzymes such as streptokinase or urokinase for dissolving the clot
- the patient has had an ultrasound on the leg, a venogram (also called a phlebogram) which includes the injection of contrast dye into the vein followed by a series of x-rays or an impedance plethysmograph
- he/she is wearing graduated compression stockings to encourage venous blood flow
- the symptoms are asymmetric and unexplained by any other means eg heavier than normal exercise, new shoes or activity etc

Caution!

When doing the massage remember that:

- clients who survive the initial episode of DVT are prone to chronic swelling of the leg and pain because the valves in the veins have been damaged by the thrombotic process
- clients with varicose veins have sluggish venous blood circulation which may encourage clotting
- DVT can occur in healthy people without any symptoms (the author knows of a Professor of Surgery at one of our leading hospitals who misdiagnosed DVT on himself and continued to work for several days despite some pain and discomfort in his leg!)
- you need to take a thorough medical history and listen to your common-sense and intuition when dealing with your clients! Sift through possible medical problems and do not be afraid to suggest to a client to see a medical practitioner before deep massage.

You can assist your clients by advising them to limit:

- sitting for long periods of time without change in position (e.g. long car trips, air travel)
- standing in one place for long periods of time without moving around
- prolonged bed rest
- tight clothing that interferes with the blood flow

AMT CALENDAR OF EVENTS

MARCH TO SEPTEMBER 2001

- The letter V indicates that the number of CEUs is Variable - depending on the number of hours attended.
- Courses accredited by AMT attract 5 CEUs per hour.
- Courses not accredited by AMT attract 4 CEUs per 3 hours.
- Please check dates and venues with the contact person before you attend.

MARCH 2nd-5th	Myofascial Release 1 – Fundamentals (32 hours). Pr esented by Paul Doney. Peridor Health Schools, Bondi Junction. Ph/Fax: 93880699	160
12th- 16 th	Sports Injury: Diagnosis and Management. Presented by Dr Paul Conneely (See Advertisement page 16) Ph: 93681215	105
16th, 17 th, 18 th	Myofascial Release, Level 1. Learning the Essentials Om Shanti College of Tactile Therapies, Griffith, ACT. Ph/Fax (02) 62952323	
24th	Reiki, Level 1, Om Shanti College. Ph/Fax (02) 62952323	30
APRIL 1st	Trigger Point Therapy, Level 1 Lower Back Pain and Dysfunction Om Shanti College. Ph/Fax (02) 62952323	30
6th-8th	Myofascial Release 2 – Unwinding (20 hours). Presented by Patricia Farnsworth Peridor Health Schools, Bondi Junction. Ph/Fax: 93880699	100
21-22nd	Reflexology L evel 1, Om Shanti College. Ph/Fax (02) 62952323	30
29th	Seated Massage, Om Shanti College. Ph/Fax (02) 62952323	30
MAY 19, 20, 26, 27 th	Myofascial Release 1 – Fundamentals (32 hours). Green Point Community Centre, Greenpoint (Central Coast) Ph: (02) 43844263	160
27th	Reiki, Level 1. Om Shanti College. Ph/Fax (02) 62952323	30
JUNE 8- 10 th	Myofascial Release, Level 2. Thoracic Spine and Respiration Om Shanti College. Ph/Fax (02) 62952323	
29th-to July 2 nd	Myofascial Release 1 – Fundamentals (32 hours). Presented by Paul Doney. Peridor Health Schools, Bondi Junction. Ph/Fax: 93880699	160
JULY 1 st	Trigger Point Therapy, Level 2 Shoulder Girdle Pain and Dysfunction Om Shanti College. Ph/Fax (02) 62952323	30
6th-9th	Myofascial Release 5 (32 hours) Peridor Health Schools, Bondi Junction. Ph/Fax: 93880699	160
AUGUST 3rd-6th	Myofascial Release 3 – Fundamentals (32 hours). Presented by Patricia Farnsworth. Peridor Health Schools, Bondi Junction. Ph/Fax: 93880699	160
11, 12, 18, 19 th	Myofascial Release 1 – Fundamentals (32 hours). Green Point Community Centre, Greenpoint (Central Coast) Ph: (02) 43844263	160
25th	Trigger Point Therapy Level 3, Cervical Pain and Dysfunction Om Shanti College. Ph/Fax (02) 62952323	30
SEPTEMBER 7-9th	Myofascial Release, Level 3. Cranial, Deep Cervical and TMJ Om Shanti College. Ph/Fax (02) 62952323	
28th to OCTOBER 1 st	Myofascial Release 1 – Fundamentals (32 hours). Presented by Paul Doney. Peridor Health Schools, Bondi Junction. Ph/Fax: 93880699	160

The AMT Annual Conference will be held on September 22 and 23 at Harold Park Racing Club. Please check the next newsletter for details.