

moving in the right direction

Mechanical Diagnosis And Therapy™
of the spine and extremities

Are You Up To Speed with Curriculum Changes?

Michelle Miller, PT, Dip. MDT

The McKenzie Institute International (MII) is constantly re-evaluating MDT education to more effectively teach the totality of the MDT system. I had the opportunity to sit down with Stacey Lyon, the Executive Director of the US branch, to clarify some recent changes that have expanded the program.

When did the MDT curriculum change?

The curriculum officially changed in the US January 1, 2011.

What is the purpose of the curriculum changes?

Since the inception of the Part E course in 2002, the aim has always been to eventually introduce MDT for the Extremities earlier in the Institute's Education Programming. The result is our new *Part C: MDT Advanced Lumbar Spine & Extremities – Lower Limb* and *Part D: MDT Advanced Cervical and Thoracic Spine & Extremities – Upper Limb*. The decision to blend the assessment of extremities and spine was determined by the importance of a clinician's ability to successfully differentiate a spine from an extremity problem and vice versa.

What specific changes have been made to the Program of Certification?

All courses are now four days.

PART A: No significant changes.

PART B: The additional time will allow for greater emphasis on headaches, thoracic spine and more hands-on techniques to be taught.

PART C: The integration of extremities begins! The introduction to the assessment and treatment of lower extremity peripheral joints and advanced lumbar spine assessment and techniques will heavily emphasize the differentiation of a spine vs. extremity diagnosis.

PART D: Continuing on with extremities to the assessment and treatment of upper extremity peripheral joint and advanced cervical spine, as well as differential diagnosis between regions.

What will not be changing?

Seeing live patients will not change. The Institute provides the only continuing education that assesses live patients on its courses. We believe this is crucial to learning how to accurately perform McKenzie assessments. It also enables course participants to see real life situations, instead of simply discussing case studies, to show what happens when someone does not fit neatly in a box.

The McKenzie assessment process itself also remains the same. This time-tested method has mounting evidence of its effectiveness. We have simply rearranged the material in the courses for a more integrated and effective learning experience.

Will there continue to be a Part E and CSU course?

Yes, we will continue to offer Part E to support the number of clinicians who have not yet studied MDT for extremities and to also help with the transition of those attendees who have already completed Part C or D. This course tends toward more advanced extremity concepts, as well as more targeted peripheral joint patient demonstrations.

The CSU class will also continue as this advanced course blends both the spine and extremities. Enrollment pre-requisite is still Part D and it is a wonderful class to attend prior to sitting for the certification exam.

What do I do if I have already taken Part C of the previous curriculum?

We want to be as flexible as we can to help with this transition, so we're allowing several options. First, you can just continue to Part D. Second, you can audit a new Part C (audit fee is half the cost of the course fee.) Third, you could attend a Part E course to get intensive exposure to the extremities and then go onto Part D, or you may realize auditing Part C might ultimately be best.

It is also highly recommended that you read the Extremity Text prior to attending Part C, D or E to more easily assimilate the vocabulary and overview of the concepts as they pertain to the extremities. Ultimately, you know your current abilities with MDT and you can best judge which route is right for you.

Can I still take the new Parts B, C and/or D even if I have taken the old ones?

Absolutely! You are welcome to repeat any course anytime at the reduced audit fee.

When will extremities be added to the Certification Examination?

MII has stated the goal to begin testing extremities is 2012.

What does this mean for those who are already certified – am I still certified?

Yes, you are still certified. However, if you have not taken the extremity course, it is highly recommended that you do so.

But there are requirements to maintain my certification; can you explain those?

You don't lose your certification; the CCES policy is to maintain "active status" on the Institute's referral directory. Options required every three years include: auditing any McKenzie course, take Part E or CSU, attend a MDT International or Conference of the Americas, publish in the McKenzie journal, or co-sponsor a course and be an active assistant. You can also find this detail in our website under the Education tab.

Why have the International Conferences been moved from every two years to every three years?

The International Conference focuses heavily on the latest research and because the development of research is often a lengthy process, MII felt it was prudent to take more time between conferences to insure conference material is the latest and greatest to offer.

When is the next Conference of the Americas?

Due to the MII change, our goal is to have the next full Conference of the Americas in 2013. The Americas region is currently exploring other options for the "off" years.

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»» What is the Right Force?

Chris Chase, PT, Dip. MDT

As MDT practitioners, we are taught how to appropriately progress force to obtain successful resolution of many musculoskeletal mechanical conditions. First, you begin with patient generated forces progressing to end range. You then add patient generated overpressure, followed by clinician overpressure, and finally clinician mobilization and manipulation. To reduce derangements, you seldom skip a force progression and you only progress the force application if you are getting an appropriate, improving symptomatic or mechanical response. But when selecting an appropriate loading strategy, at times you need to think about atypical force modifications rather than just increasing force. Two recent patients from the Austin Diploma training site highlight different strategies for appropriately treating a patient when increasing the force is not giving you a favorable response.

A 60 year old patient, with a long history of back pain with a self-reported acute and visible lateral shift, presents with intense leg symptoms. Both flexion and extension movements produced increasing peripheral symptoms. We first attempt to reduce the lateral shift with shift correction in standing. Unfortunately, any attempt at moving her into a side-glide overcorrected position sent increased peripheral symptoms below her knee. Our diploma resident suggested we try flexion rotation, but I suggested we should still try and correct the shift in standing. His immediate response was "but the symptoms are peripheralizing." At this point, we instructed the patient to perform SGIS against the wall, but to only move in very small oscillations and to avoid producing peripheral symptoms. After approximately 20 or 30 small amplitude side glides, she began to gain movement and was no longer feeling symptoms into her leg. She was encouraged to now add gentle overpressure (OP) and push towards end-range. With more repetition, she was able to centralize her leg and thigh pain to her back and reduce her lateral shift. Once her lateral shift was reduced, her extension regained easily; and eight visits later, she was discharged with full resolution of her pain and all her goals 100% met. When asked to explain how I justified staying with a movement that produced peripheralizing pain, I answered "force regression." Sometimes, less force with higher repetitions gives you a more desirable response, especially for a large lumbar lateral shift, which maintains reduction best in a loaded position.

Our second patient was a severe, 14-day old lumbar derangement with radiating thigh and calf symptoms and intermittent shooting flank to

base of skull pain coming from his right low back. He was obstructed to movement in all directions and reported 10/10 pain with all attempts to move. His primary symptom was buttock to foot pain that was constant. He had injured himself at work lifting a heavy object and had been seen by an occupational medicine physician and had negative x-rays. Our diploma resident first checked for a lateral deformity, for which there was no visually obvious shift. Our resident decided to first test a sustained prone position by having him lie over two pillows. While uncomfortable at first, his pain fairly quickly started to decrease in intensity. Periodically, we attempted to move him into extension by removing pillows, but any attempts to put him even into mild extension in lying would peripheralize sharp pain into his leg. He was instructed in a self treatment program of sustained extension using symptom location and intensity to direct his vigor of attempted extension. Three days later (Monday), he reported his pain level was decreased, he had slept better, and he hadn't had any flank or head pain and was moving slightly better. But, he still could not perform EIL without peripheralizing symptoms. Our diploma resident, at this point, wanted to try lateral techniques, but I suggested before we do that we mobilize him into extension. He immediately questioned my choice and asked "if it would be inappropriate to add mobilization when the patient couldn't even attain end range extension dynamically." My response was before leaving the sagittal plane, force progression may be appropriate even before achieving end-range extension, as long as you have confirmed directional preference. After approximately three sessions of increasingly more forceful extension mobilization, the patient was able to perform REIL, without peripheralizing symptoms. With four weeks of treatment, including mobilization, the REPEX table, and then recovery of flexion, he had a full resolution of his derangement and met all his goals.

These two challenging presentations allow us to incorporate treatment strategies that were slightly atypical. They prompted good discussion that reminds us that sometimes we must make adjustments to the force rather than abandoning the direction. The condition may respond better to increased repetitions of a small force or progressing force, before trying an alternate loading strategy. Other suggestions may include using time and sustained positions, using combined plane movements, or high frequency mid-range movements, as well as many others. As long as you listen to the symptomatic changes and follow the principles of MDT, you can trust you will provide safe, effective treatment for your patients.

Introducing Your Talented Editorial Team!

The MDT Bulletin has reached greater heights due to the leadership and dedication of our skillful editorial team to keep you informed with the latest news, business ideas, and clinical insights.

Your MDT Bulletin editorial team consists of:

- **Susan Bamberger, PT:** Susan received her MDT Diploma in 2009 and is currently President of the Oregon chapter of the APTA. She brings a wealth of knowledge to the team by providing insight from her political involvement. s.bamberger@comcast.net
- **Christopher Chase, PT:** Chris attained his MDT Diploma in 2009, and recently joined the Austin Diploma training site as an Assistant Diploma Educator after working at a McKenzie Certified Clinic for over five years. Christopher.chase@stdavids.com
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If you have any ideas or contributions, the team invites you to email them directly. Any insight you may have for future articles would be greatly appreciated. Let's work together to advance our knowledge, skills and the future of MDT.

»» Fun When the Patient Teaches the Therapist a New Trick

Audrey Long, BScPT, Dip. MDT

Robin McKenzie said that every patient contains the truth. Before my MDT training, I always took the patient's history, but I'm sure I did not interpret the information very well, and I'm even more sure that I failed to draw out some good information altogether.

I love stories about patients who discover their own modification of a self-treatment trick. The following tidbit, which appeared on the McKenzie Listserv*, brings this all together - the truth contained in the patient, how the right question can draw out those gems of truth, and a patient who discovered her own technique.

In early November, I assessed 62-year old "Betty". Her presentation was not uncommon. Although a shift was not apparent when she walked in, a right shift was apparent after she arose from sitting for the history. At first, she said her left leg pain was constant, but when I asked if it ever stopped for even a short time, she said yes. Therefore, Betty's leg pain was intermittent, but it certainly was there most of the day. Her pain increased some with sitting and bending, but was especially provoked with standing or walking. Walking intolerance was her chief complaint and reason for seeking care.

She had left leg pain in the L4 distribution with a "soft", but relevant, right shift, no hard neurological signs, and symptoms were of gradual onset over four months. We had to let her flex by leaning on the treatment table, while doing left side gliding, in order to initiate centralization because she peripheralized with SGIS.

That's enough information to start effective treatment, but I would not have learned a new trick if I had not asked one more question. Her left leg pain was almost always there, so I asked her "**when** does the leg pain shut off?" Betty replied, "When I pull my left leg over".

Oh? Show me. She demonstrated the following while I sat in front of her and mirrored her movements (try this yourself):

She sat with a small pillow in her back (big pillows or full lordosis made her leg pain worse), then she crossed the left ankle over the right. Using the right ankle to slowly pull the left ankle/leg to the right, she kept pulling until her left ankle was as far to the right as she could get it. She held that position, and in less than five minutes, her left leg and thigh pain abolished, but didn't remain better with walking. As she demonstrated this movement, her trunk moved to the left, creating a left shift in sitting.

When I tried this manoeuvre, I noted that as my left foot and lower leg were pulled to the right, I could feel myself counter balance and this created a left side glide movement until I was in a left shift in sitting. I could feel myself side gliding. Cool, she had discovered a version of side gliding on her own!

The clinical reasoning pattern all fits. Betty was worse walking, worse with postural correction, and worse with EIS and displayed a relevant right lateral shift in standing. It made sense that she could centralize with left side glide in sitting, because this "correlated" with the fact that she needed flexion to perform side glide in standing, and that she would benefit from rotation in flexion when we assessed it on day two. On rare occasions, I've had patients who could not stand and were only able to initiate side gliding in sitting in a chair by gliding the shoulders or sitting on a ball and moving the hips. But, I had never seen it done this way.

I have had the opportunity to try this with three other patients who needed to flex when trying side glides and two liked it. Two out of three is not bad.

Thanks, Betty, for teaching me a new trick or at least making that an interesting session.

* <http://health.groups.yahoo.com/group/McKenzieStudy/>



The McKenzie Institute International

12TH International Conference in Mechanical Diagnosis and Therapy

5-7 October 2012 Austin, Texas, USA



»» Breakfast with the Physical Therapist

Yoav Suprun, DPT, Dip. MDT, CSCS

Tired of chasing doctors in your area for business? Three years ago, I decided something needed to change. Doctors must learn about MDT from their patients via word of mouth.

Since opening my clinic in Miami Beach three years ago, I chose to market only to patients and teach them about MDT. Can *you* do this? Sure you can!

How do you get your patients to tell their doctor, "I want to see that McKenzie practitioner because I think my problem is mechanical"? Well, it starts with "educational marketing". Teach the possibilities of where aches and pains may come from and they will often want to know more. The language of MDT makes sense to people. They can relate to it, because the majority of aches and pains have a mechanical component.

Coffee shops or local gyms are a great start. In my case, I chose a coffee shop two blocks from my office, inside a Whole Foods store. I posted a sign on their free cork board titled: *"The truth about lower back pain and sciatica. You are invited to join a physical therapist for a free educational lecture. Learn about common causes and a method that teaches you SELF treatment for back pain and sciatica"*.

On a Friday morning, three people came to my first talk. We each had breakfast, while sitting around my laptop. We were discussing mechanical LBP and sciatica. I had with me a PowerPoint presentation, three different spine models, a lumbar roll, a Treat Your Own Back book, and Dr. Donelson's book "Rapidly Reversible Low Back Pain".

The coffee shop is located just in front of the registers at Whole Foods, so people looked at us sitting around my laptop and four more joined the

conversation. I handed my cards to numerous prospects and got three office bookings and one home care.

The following week, I had eight people waiting, including the sister of a gentleman who came to my first talk. She came to see me for neck pain and reported, "I have good and bad days...I saw a chiropractor, which helped, but it keeps coming back."

After resolving her problem in a couple of visits, she was so thankful that she called her primary care physician (PCP), as well as connecting me to a local gym, where she is a member. I gave a talk to the trainers who also started referring clients to me. I became the gym's "mechanic". Also, I treated her PCP and as a result, I have doctors who refer to me, despite never once visiting their office.

The breakfast talks continue to generate business. Other titles are "Pain in the neck?", "Is your workout making you worse?" and "Do you really need arthroscopic knee surgery?"

Word of mouth works BEST. However, you must do right by the patient and not sell them the old and tired story of "You need to see me three times a week for four weeks".

Important tip – even if one person shows up, you never know how that person can boost your business...keep pursuing education of the public and they will come.

Search in your area for a good opportunity to give a free talk, even once a month, and see what will happen to your business. I am sure you will be surprised!

A RESOURCE TO HELP YOU PROMOTE MDT

You know what McKenzie is all about, but do your colleagues?

With CEUs requisite in the majority of states for PTs, encourage a colleague to pursue this effective, low-cost learning opportunity that will help your peers appreciate the strength of MDT and what you do so well!

"The McKenzie Method: The Scope and Application of Mechanical Diagnosis and Therapy" is an introductory course that provides an understanding of the scope and application of MDT to musculoskeletal disorders of the spine and extremities. This two hour audio course, developed by McKenzie Institute faculty Richard Rosedale, Kathy Hoyt and Robert Medcalf, covers:

- ◆ Evidence supporting MDT
- ◆ The principles of the MDT system of classification
- ◆ Why the need for the classification of musculoskeletal disorders
- ◆ Structure of the MDT assessment process and outline of specific MDT classifications
- ◆ Case studies to demonstrate the clinical reasoning process
- ◆ Videos of Robin McKenzie speaking and treating patients

All the ease and convenience of online learning, on a full audio-visual platform that allows you to see the presentation, hear the professor and interact as needed.

The target audience is health care professionals, students, or researchers in musculoskeletal care, as well as, faculty at University health care programs. It is also a perfect warm up for those who plan to take our courses and pursue certification in MDT.

Visit <http://www.mckenziemdt.org/eduOnlineEducata.cfm> to learn more!

