HANDS-ON

Editor Jim Meadows

This Issue: AAOMPT Conference

Volume 2, Issue 4

July 2005

Inside this issue:

Editorial: Summer Thoughts

So summer is just about on us although you wouldn't think it if you lived in some parts of Canada. The last things thon the minds of rational therapists everywhere are continuing education and the profession's development but unfortunately this is the time that they need to be considered. The American Academy of Orthopedic Manual Physical Therapy (AAOMPT) and the Canadian Academy of Manual Therapy (CAMT) are both planning and taking registrations for the annual conferences this Fall. AAOMPT's 11th Annual Conference will be in Salt Lake City, Utah. October 14-16, 2005 and the keynote speakers will be Gwen Jull, and presumably because they couldn't get anybody else, me. The final few pages give details on this conference including registration information but if you prefer you can go to AAOMPT's web site at http://www.aaompt.org/AAOMPT_conference.htm

CAMT's annual conference will be run concurrently with the 17th, Annual Conference of the Orthopedic Division of the CPA in London, Ontario, October 28-30. where the speakers will include Peter O'Sullivan, Alan Beggs, Stuart McGill Anita Gross and others. For further information go to http://londonorthounit.org/events/17thSymposium.html

If you are a member of a Fellow of either of these organizations and you are able you really should attend. Apart from everything else if you are there it prevents you be appointed or elected to office by unscrupulous colleagues who take advantage of the situation that arises when you are not in a position to say no. But more importantly it gives you the opportunity to attend outstanding lectures, pre and post-conference courses, to have a say in the running of your academy and how your money is being spent, to renew old friendships, make new friends and hone your skills on avoiding people you would rather not meet.

Upcoming Courses

Level 2 Upper	St. Louis Mo	Jul 15-17 and Aug 5-7
Spinal Manipulation	Calgary, AB	Aug 12-14, Aug 19-20 and Sep 16-18
Acute MVA	Tulsa, OK,	Aug 26-28

Winter Spinal Manipulation Course Edmonton, AB, Canada

See main calendar for rest of course dates
For further information on courses contact jim@swodeam.com

Upcoming Price Change on DVDs See Back Page for Details

March's Who Said it?

Facts are stubborn things, but statistics are more pliable.

Mark Twain (1835 - 1910)

July's "Who Said It"

Not to be absolutely certain is, I think, one of the essential things in rationality.

This is one quote that everybody knows but few know who said it.

God, give us grace to accept with serenity the things that cannot be changed, courage to change the things which should be changed, and the wisdom to distinguish the one from the other.

Screening Tests

A screening test is not the same as the scan examination. The scan examination is poorly named and is the term that has, unfortunately, superceded Cyriax's term "selective tissue tension tests". Unfortunately because the word scan implies a quick superficial look whereas the Cyriax examination is possibly the most comprehensive clinical differential examination of the neuro-orthopedic system that we have. A screening test is one that short-cuts a more detailed examination in order to focus the examiner on a region, a segment or a particular movement. By its very nature a screening test cannot be as comprehensive or as detailed as a full examination and this weakness must be realized and fully understood if the test is to be used effectively. This is the heart of the screening test it is capable of including but not capable of excluding. It cannot replace the full examination unless it is as sensitive and as specific as the full examination. If it is then it is no longer a screening test but the gold-standard test. These are the tests that, for us at least, are most in need of criteria validation so that sensitivity and specificity numbers are known, that is we know how much faith to have in their ability to include the area or movement in a full examination.

To summarize to this point, the screening tests are quick non-comprehensive tests that focus the examiner's attention on a region, segment or movement they are capable of including but not in definitively excluding the joint or segment from further examination; they cannot be as good as proper testing but they do save time and effort.

In previous issues we discussed remote etiologies, victims and culprits (Erl Pettman's excellent phrasing), and said that the noisy victim may be some distance away from the silent culprit. This means that an entire quadrant (and some times both quadrants and sometimes even all quadrants) have to be explored to find the etiology, a prolonged and difficult task. To reduce the work load screening tests can be used to include in joints and regions for more detailed examination and to provisionally screen out regions that have low probability for involvement in the patient's problem. If you look back at the last sentence you will note that I used the word "provisionally" and this was quite deliberate. No screening test is as good as a full examination, if it was it would be the examination. For example when looking for the cause of a non-structural long leg dysfunctions of the foot, ankle, knee, hip, sacroiliac joint and lumbar spine would all have to considered as possible contributing factors. A complete examination of all of these regions would be prohibitive especially in today's cost conscious world of clinical practice. This is where screening tests come into their own. A screening examination of the biomechanics of the lower quadrant can be carried in a few minutes allowing the examiner to concentrate on the one or two regions/joints that showed positive tests. If, however, all of the screening tests were negative or the ones that were positive led to examinations that were not convincing then all of the lower quadrant would have to be examined in detail.

Screening tests have recently become almost de rigor and as such are being used inappropriately. Inappropriate use would be when they are used in place of an examination that is as fast as they are, for example position testing of the neck is pointless for a number of reason but mostly because it is not significantly any faster than testing with side flexion/translation in flexion and extension. They are inappropriate when they are used in the wrong sequence as exemplified by position or kinetic testing of the sacroiliac joint during the differential diagnostic examination. The purpose of the DDx examination is to make a medical diagnosis while the purpose of the position or kinetic tests is to screen for the biomechanical examination.

Starting in this issue we will look at various screening tests, some in common use, some hardly known and a few that are commonly used but not commonly recognized for what they are and try to understand how good they are and how they are best used.

Letters and Comments

I received a letter regarding the article on tennis elbow in the last issue, it concerned neural dynamics and the possibility of tennis elbow being misdiagnosed for neural dynamics pathology. My position is that essentially this is impossible because of the quality of pain but I will address this in more detail in the next issue. Essentially I will take the position that pretty much all research states that unless there is neuropathic pain, parasthesia or neurological deficit it is unreasonable to attribute somatic symptoms to the neurological system. You Butlerites can take me to task after the next issue.

Swodeam Courses 2005

2005

	Course	Location
Jan 7-9	Level 3 Lower	St. Louis, MO
Jan 14-16	Chronic MVA	Fairfax, VA
Jan 22-24	Acute MVA	Helena, MT
Jan 28-30	Level 3 Lower	St. Louis MO
Feb 4-6	Spinal Manipulation (1)	Dallas, TX
Feb 11-13	Upper Limb	Baltimore, MD
Feb 18-20	Spinal Manipulation (2)	Dallas, TX
Feb 25-27	Level 3 Lower (1)	Madison, WI
Mar 10-15	Level 3 ?	Colorado Springs, CO
Mar18-20	Level 3 Lower (2)	Milwaukee, WI
Apr 1-3	Level 3 Upper (1)	Fairfax, VA
Apr 22-24	Level 3 Upper (2)	Fairfax, VA
Apr 29-May 1	Spinal Manipulation (3)	Dallas, TX
May 6-9	Manual Therapy Symposium	Quebec City, PQ
May 13-15	Spinal Manipulation (1)	Syracuse, NY
May 20-22	Peripheral Manipulation	Freemont, CA
June 10-12	Chronic MVA	Boston, MA
June 14-20	NAIOMT Conference	Washington, DC
July 15-17	Level 2 Upper (1)	St. Louis, MO
July 22-24	Spinal Manipulation (1)	Calgary, AB
July 29-31	Spinal Manipulation (2)	Calgary, AB
Aug 5-7	Level 2 Upper (2)	St. Louis, MO
Aug 12-19	Spinal Manipulation (1)	Calgary, AB
Aug 19-21	Spinal Manipulation (2)	Calgary, AB
Aug 26-28	Acute MVA	Tulsa, OK
Sep 9-12	Differential Diagnosis	Portland, OR
Sep 16-18	Spinal Manipulation (3)	Calgary, AB
Sep 23-25	Differential Diagnosis (1)	Dallas, TX
Oct 2-4	Chronic MVA	Berrien Springs, MI
Oct 7-9	Chronic MVA	Detroit, MI
Oct 12-13	Cervical Manipulation	Salt Lake City, UT
Oct 14-16	AAOMPT Conference	Salt Lake City, UT
Nov 4-6	Level 3 Lower (1)	Fairfax, VA
Nov 11-13	Spinal Manipulation (1)	Edmonton, AB
Nov 19-20	Spinal Manipulation (2)	Edmonton, AB
Dec 2-4	Level 3 Lower (2)	Fairfax, VA
Dec 0-11	Lumbopelvic	Baltimore, MD

All courses unless specifically stated are combinations of lecture and lab, usually about 50/50. Each course is organized by a local coordinator and for contact to that person please email Jim Meadows at jim@swodeam.com

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For further information on courses contact jim@swodeam.com

Two Screening Tests for Lower Quarter Pain

Here are two little known but, I think, highly useful tests for the lower quadrant. They both help in differentiating the source of the pain but not the cause of it. Remember when you read them that the purpose of screening tests is not to make a diagnosis but to concentrate your attention on the area most likely to be the problematic one.

Fortin's Finger Test

This is one of those tests that you really wished that you had designed. It is so simple and obvious that you wonder why you didn't think of it. Fortin's is a test for determining the likely-hood that the patient's low back pain is arising from the sacroiliac joint, not that the sacroiliac joint is causing the pain but that the joint is the source of the pain. The difference is not particularly subtle and it is important. As was discussed in the last issue the source of the pain is often the victim and not the criminal but it must be dealt with if only in that it receives stress relief by treating the hypomobile cause. But to be sure that the treatment of the silent hypomobility is appropriate the source of the pain must be established so that a logical interpretation of the clinical findings can be made. This is where Fortin's finger test comes in with low back pain. Obviously

The essentials of the test are as follows. The patient is asked to point with one finger tip to what he/she considers either the source of the pain or where the pain is felt to be centered. A positive test is one where the patient points to an area just medial and slightly inferior to the posterior superior iliac spine a negative test is where the patient points anywhere else. If the test is positive there is a probability that the pain is arising from the SIJ. As importantly, or perhaps more importantly, if the test is negative there is almost no chance that the pain is sourced from the SIJ. It must be stressed though that the test does not say anything about whether there is a SIJ dysfunction just whether or not any dysfunction is painful.

A modification of the test is called Fortin's finger sign, although there is no indication that Fortin intended this. It is finger tip palpation tenderness over Fortin's area.

Fortin's finger test was validated against pain provocation injections and was found to be extremely sensitive (almost 100%) and moderately specific (about 70%). So a patient with a positive test has a little over 2:1 chance of being caused by sacroiliac pain but a little over 3:1 chance against it being caused by an extra-SIJ pathology. On the other hand with such a high sensitivity there is very little chance that the patient with a negative test has pain that is sourced from the SIJ. This test is extremely useful to us in identifying the noisy victim but does nothing for determining who the silent victim is.

Extrapolating from this tests validity numbers we can now rationally discuss what makes a pain provocation test positive for the sacroiliac joint. Cyriax who stated that for the two sacroiliac stress tests he described (the so-called anterior and posterior gapping tests) to be positive the pain must be unilateral and over the SIJ (Fortin's area) or over the anterior groin if the ventral ligament was injured. The researchers have finally caught up with the clinician and have validated Cyriax's position. There is, however, a complication with Fortin's as a screening test. Most studies looking at the pain provocation (primary SIJ stress tests) fail to demonstrate either reliability or validity and while many of these studies have errors associated with them that would make the clinician suspect the study rather than the test there is sufficient uncertainty about the tests to make having much faith in them difficult. With the Fortin's finger test there is little uncertainty about the test or how good the test is. Consequently the Fortin's test far from being a screening test may actually be our best clinical test for determining how likely the SIJ is to be the pain generator and as it is difficult to imagine a test that could be more time efficient no screening test leading to Fortin's is required.

Stinchfield's Test

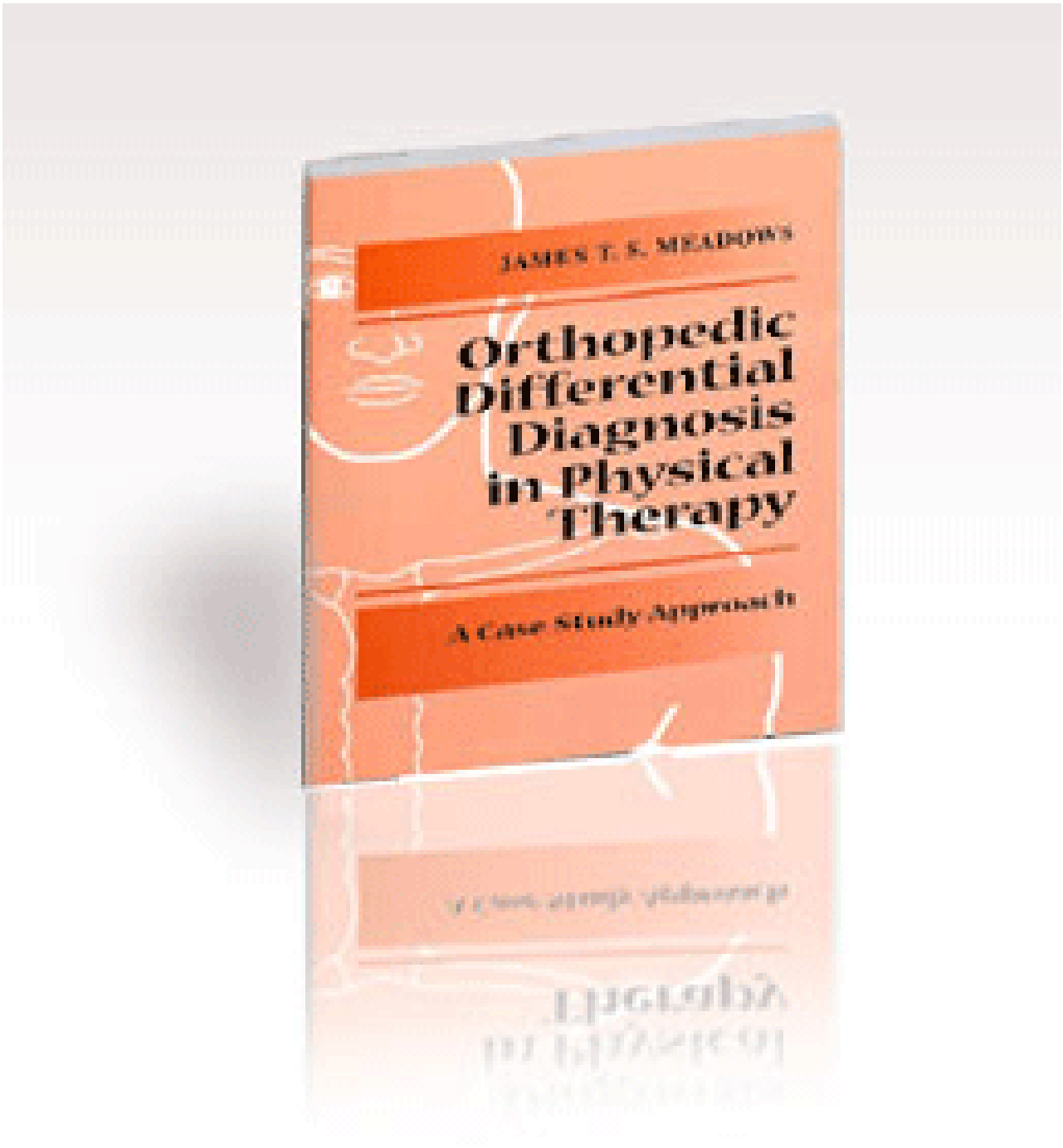
Stinchfield's test is designed to determine the source of the patient's back, buttock, groin and or leg pain. The patient is laid in supine and asked to lift the straight leg to about 30 degrees, if no pain is provoked the examiner applies pressure downwards in an attempt to extend the flexed hip while the patient resists the force. Pain produced either with or without examiner resistance is assessed for location. If the pain is felt in the groin or anterior thigh it is considered to arise from the hip, if from the buttock or lumbar spine it is from the sacroiliac joint or lumbar spine.

Stinchfield's should not be confused with the straight leg raise for neuromeningeal problems. The latter is passive and the former active and usually resisted, additionally Stinchfield's is not dependent on the range obtained but on the location of symptoms. The only manner in which the two could be confused is if a lumbar lesion was producing a restriction of the SLR at or below 30 degrees. In this case the other signs and symptoms would be so obviously discogenic that Stinchfield's test would not even be a consideration.

Unfortunately Stinchfield's has not been subjected to criteria validity research as Fortin's has been, so no sensitivity or specificity numbers are available to the clinician. However using the information gleamed from Fortin's study on SIJ pain Stinchfield's can be refined. Pain felt in Fortin's area may be considered to arise from the SIJ while all other pain is from the lumbar spine or hip. Now the problem of specificity is reduced as Fortin area pain can now be considered likely to arise from the SIJ and non-Fortin area pain from the spine or the hip. When there is no pain in Fortin's area and the SIJ is not a consideration any longer, the question is now between groin/thigh pain and lumbar pain. The division is much more clear-cut and the test becomes more useful.

The use of Stinchfield's test should now be obvious, it is to determine the source of symptoms and the tests that will be required to make a specific diagnosis, however, remember that the sensitivity and specificity values that are present with Fortin's are absent with Stinchfield's so great care must be taken when eliminating areas and pathologies.

Fortin's finger test is highly sensitive and moderately specific for determining if the patient's pain is arising from the SIJ.



Orthopedic Differential Diagnosis in Physical Therapy by Jim Meadows deals with the analysis of the subjective and objective examinations primarily based on the concepts of James Cyriax. The book is in three parts, the first discusses general principles in diagnosis, the second with specific issues in each spinal region and the third offers interactive case histories that use the principles detailed in the earlier sections of the book. The book is intended for all levels of physical therapist including the pre-professional student.

Prices vary but average out at about $40 US and the book may be purchased through Amazon.com or ordered through a local medical book store. Swodeam Consulting does not sell the book by arrangement with the publishers Magraw-Hill.

Manual Therapy Videos Now Available in DVD.

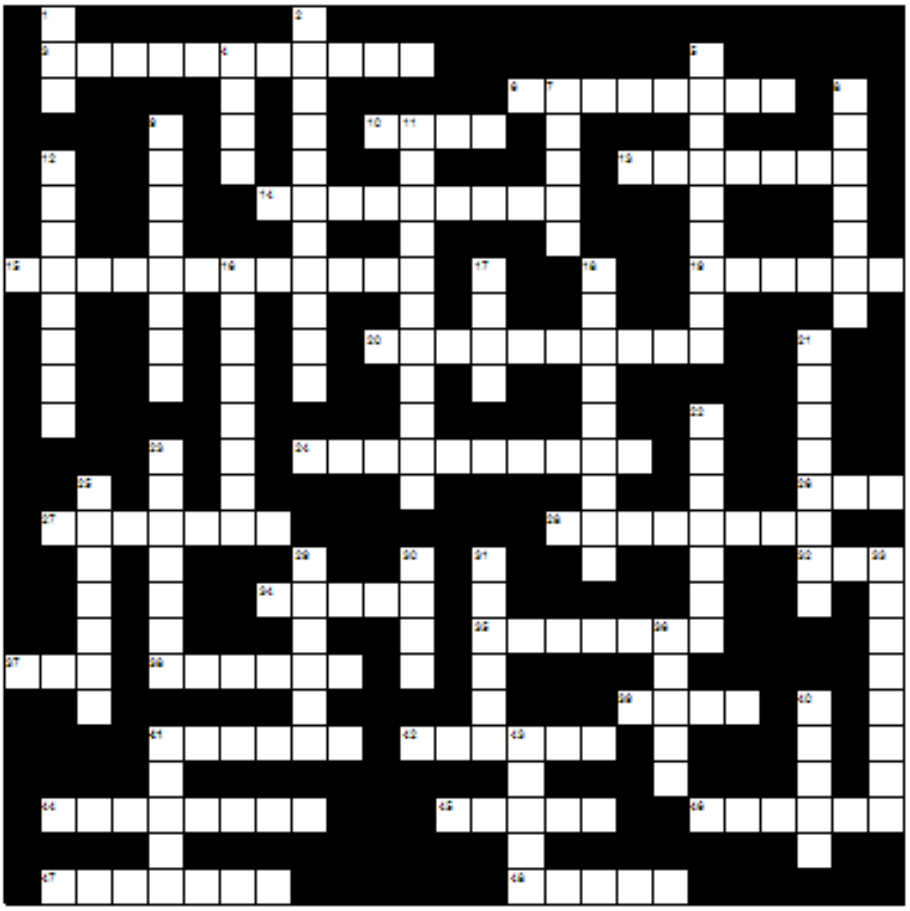
The video series manual therapy is now available on DVD. The VHS tapes have been converted to into 10 DVDs each with an interactive menu. The 10 discs cover differential diagnosis, selective tissue tension testing basic and advanced biomechanical examination and diagnosis, biomechanical treatment and the assessment and treatment of the post-MVA patient. All areas of the body including the spine, peripheral joints, TMJ, SIJ and ribs are covered.

The video was made and produced at KWGN-TV in Denver, CO and as such is of professional quality and includes picture-in-picture of picky or complex techniques.

The full retail cost of the set is $700 but for a limited time subscribers to Hands-On and previous students of Jim Meadows and to past purchasers of the tapes can buy the set at 50% discount, a cost of $350 including mailing and handling (Canadian Dollars at par with US Dollars). To order send a cheque made payable to James Meadows to:
413 Interamerica, Ste. 1
PMB AJ01-7,
Laredo, TX, 78045

For further information go to my web site at www.swodeam.com or contact Jim Meadows at jmeadowspt@aol.com or by phone at 586 596 7424.

July 2005



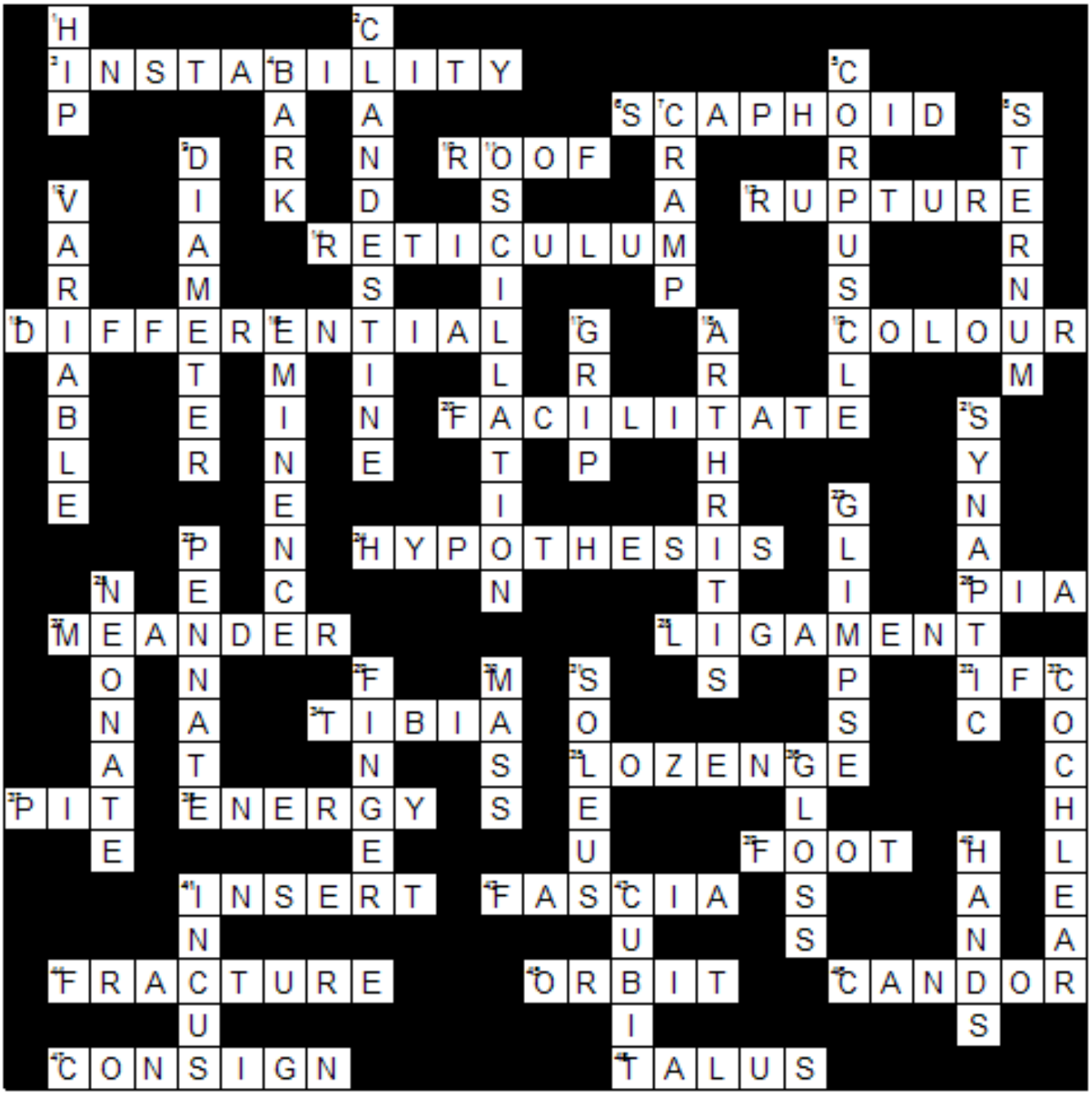
Across

3. RESULT OF A POOR BASE
6. FOUND IN THE WRIST
10. FOUND IN THE MOUTH BUT NOT IN THE HOUSE
13. A MUSCULAR DISCONTINUITY
14. A RESTRAINT FOR A TENDON PERHAPS
15. A TYPE OF DIAGNOSIS
19. AN ENGLISH ENGLISH TINT
20. MAKE EASIER
24. A QUESTION FOR THE RESEARCHERS
26. A LAYER
27. WANDER
28. USUALLY RUNS BETWEEN BONES
32. A SHORTENED ELECTRICAL TREATMENT
34. SHIN
35. A THROAT TABLET THAT RHYMES WITH ORANGE
37. FOVEA
38. WHAT FOOD GIVES
39. ANOTHER BODY MEASUREMENT BUT ONLY THE USA
41. WHAT A MUSCLE DOES
42. IT ENVELOPES THE MUSCLES
44. A BONY DISCONTINUITY
45. A CIRCUIT OF THE EYE
46. OPENNESS
47. TO SEND
48. WHERE A DOME FRACTURE MAY OCCUR

Down

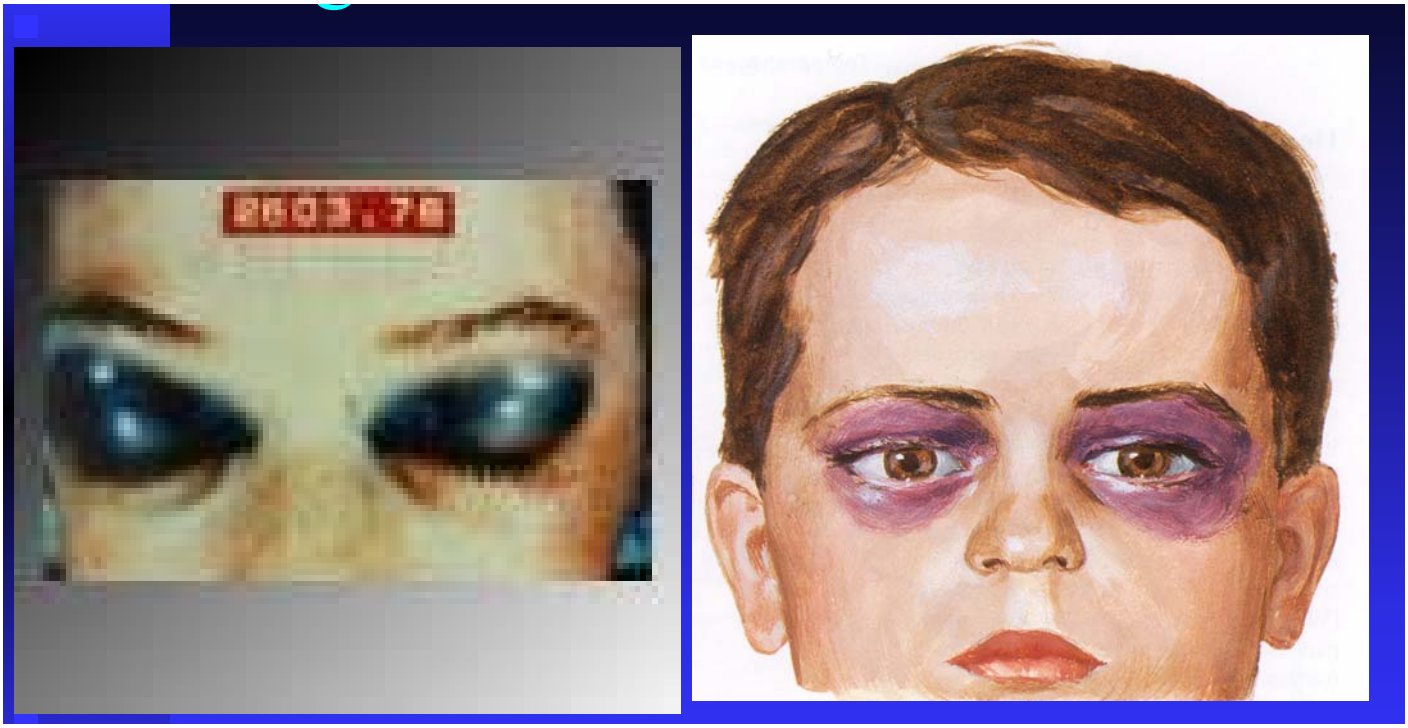
1. AN UNMODIFIED OVOID JOINT
2. SECRETIVE
4. THE NOISY PART OF A TREE
5. BLOOD BODY
7. HAPPENS TO YOUR MUSCLE AND YOUR STYLE
8. A SEVERE BONE
9. TWICE THE DISTANCE OF THE FOREARM BONE
11. A SINGLE MOBILIZATION
12. THE WEATHER OR A COMPONENT OF AN EXPERIMENT
16. ONE FOUND ON EITHER SIDE OF THE HAND
17. OFTEN TESTED FOR C8 STRENGTH
18. JOINT DISEASE
21. PERTAINING TO A NEURAL CONNECTION
22. CAUGHT WITH A GLANCE
23. FEATHER LIKE FORM FOR A MUSCLE
25. NEWLY ARRIVED
29. IT IS BOTH A FOOD AND WHAT THAT FOOD IS EATEN WITH
30. A RELIGIOUS CEREMONY OR WHAT MATTER HAS
31. A CALF MUSCLE
33. A SENSORY ORGAN
36. SHINE
40. THESE BODY PARTS MEASURE HORSES
41. EAR BONE
43. THE DISTANCE BETWEEN THE WRIST AND THE ELBOW IN OLDEN TIMES

JULY 05


HC
INSTABILITY C
P A A SCAPHOID S
D R N ROOF R R T
V I K D S A RUPTURE
A A RETICULUM U R
R M S I P S N
DIFFERENTIAL GA COLOUR
A T M I L R R L M
B E I N FACILITATE S
L R N E T P H Y
E E I R G N
P N HYPOTHESIS L A
N E C N T I PIA
MEANDER LIGAMENT
O N F M S S P IFC
N A TIBIA O S C O
A T N S LOZENGE C
PIT ENERGY S E L H
E E U FOOT H L
INSERT FASCIA S A E
N U S N A
FRACTURE ORBIT CANDOR
U I S
CONSIGN TALUS

April's What's the pathology Solutions

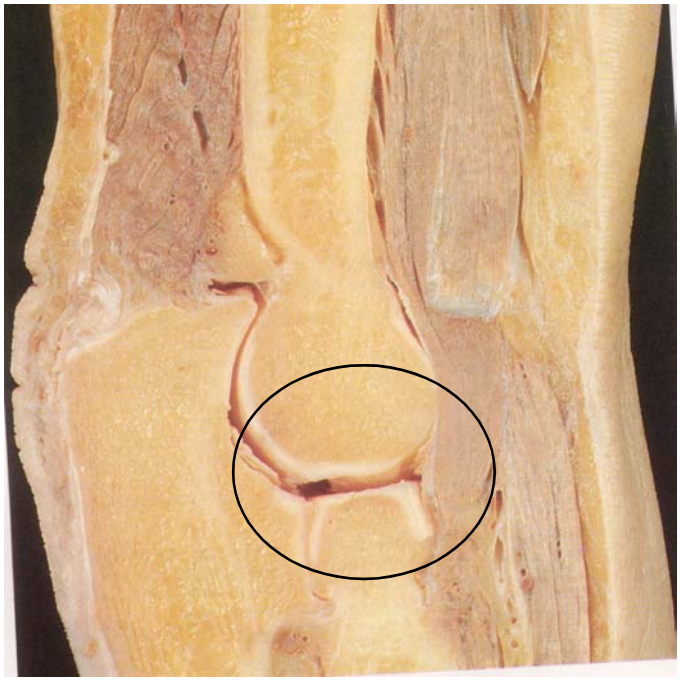
You would see this after trauma such as an MVA where there was a direct blow to the head. What is it?



This is the Raccoon Mask or Raccoon Eyes. Black-eyes but the conjunctive remains clear. It is caused by a fracture to the base of the skull most commonly an anterior basal fracture when the blood drains into the area. It is always a red-flag.

April's What's the Structure Solution

The Radiohumeral Joint



March's Quizzes for Fun Solutions

Anatomy.

1. What are the primary differences between the lumbar disc and the cervical disc in adults

The lumbar disc retains and nucleus and the cervical disc does not (except the lowest disc) and the cervical disc develops transverse clefts that divide the posterior aspect of the disc into separate parts top and bottom,

2. What is the principle difference between the lumbar disc and the cervical disc in the neonate

The nucleus of the lumbar disc makes up about 2/3 of the total volume of the disc while the cervical nucleus only makes up about 1/3.

3. What structure forms the anterior aspect of the zygopophyseal joint

The ligamentum flavum

4. Which nerve supplies the sensation to the disc and zygopophyseal joints

The recurrent meningeal or sinuvertebral nerve

Pathology.

1. Define the term "contained disc herniation

The altered "inflamed" nucleus invaginates the anulus and upon reaching the innervated outer part of the anulus can become painful. There is no significant bulging unlike the prolapse which is also contained by the anulus it is less organized in its migration. (see this month's article)

2. Pressure on the cauda equina results in which, upper or lower motor neuron signs

This can be upper or lower or mixed depending on which part of the cauda equina is hit. If the conus is compromised there will be some elements of upper motor neuron involvement.

3. Describe the characteristics (distribution and quality/nature) of nerve root pain

Nerve root pain is neuropathic so the pain will be felt as either lancinating (electric shock-like) or causalgic (hot, dry, burning and itching) and will be dermatomal in distribution. Other forms of pain such as aching, stabbing (that is somatic in nature) are not sourced from the nerve root but may be generated by the dural sleeve, the disc itself or any other structure that is capable of nociception.

4. What are the pre-eminent signs of an uncontained lumbar disc herniation based on best evidence

Limited range of motion, restricted SLR and X-SLR and difficulty in walking. Neurological signs and symptoms are secondary.

Research.

1. What is the main thing that differentiates a theory from speculation

The theory should be testable and be able to predict future events

2. What is a systematic error in terms of reliability measurement

Systematic error is predictable and consistently over or under-represent the true score.

1. What is prevalence

The incidence or number of cases that exist in a specific population at any one time.

1. What is the difference between a case study and a single-subject design

A case study is a retrospective scholarly report on a specific patient, it includes all of the pertinent details of the case plus a report on the literature relevant to the case. A case history is a retrospective non-scholarly report of a particular case with the pertinent details of the case but not of the literature relating to the case. A single-subject design is a prospective controlled clinical trial with the intervention as the variable and the patient as an auto-control. Done properly this is as rigorous a scientific method as any other in health care and may well have more meaning to clinical practice than most.

July Quiz for Fun

Anatomy

1. What is the function of the anular ligament of the elbow
2. What are the bands of the medial collateral ligament of the elbow and what are their attachments
3. The subaconeus has another name what is it and what is its function
4. The pronator teres muscle has two attachments what are they and what is the clinical significance of them.

Research

1. Define the term epidemiology
2. What is the difference in the terms “theory” and theoretical”
3. Define the term relative risk.

Pathology

1. Does the following presentation suggest tendonitis or tendonosis:

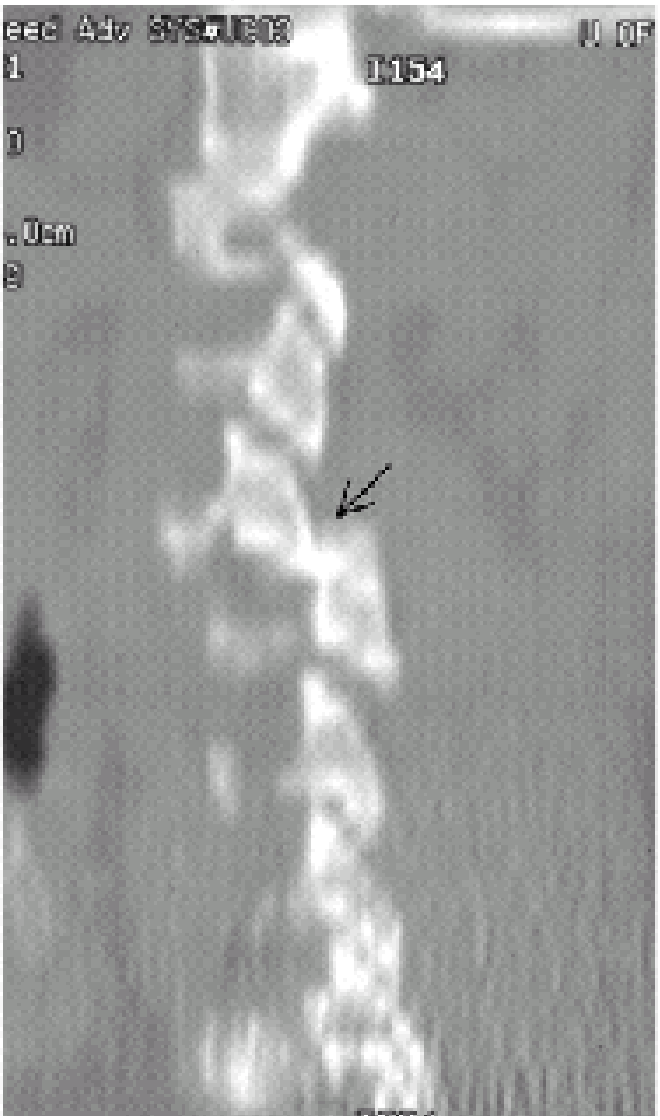
- Moderate pain
- Low irritability
- Strong and painful isometric contractions
- Moderate tenderness

2. What diagnosis does the following presentation suggest at the elbow:
- Limited flexion and supination
- A pathomechanical end feel with the lateral ulnohumeral glide

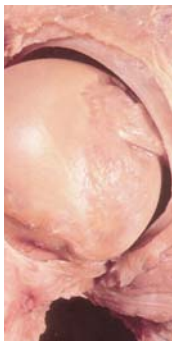
3. What diagnosis does the following presentation suggest at the elbow:
- Limted flexion and pronation
- A pathomechanical end feel with the superior radiohumeral glide

4, According to Cyriax (and I know nobody likes according questions but there you go) what is the normal time that a tennis elbow will last for providing it is not treated with injection.

What's the Pathology



What's the Structure



The American Academy of Orthopaedic Manual Physical Therapists
11th Annual AAOMPT Conference

October 14-16, 2005
Sheraton City Centre
Salt Lake City, Utah

"Manual Therapy of the Upper Quarter: Bringing it all together"

Distinguished Guest Speakers

Gwendolen Jull, MPhty, PhD, FACP

Jim Meadows

Pre Conference Courses

October 12-13, 2005

HOTEL INFORMATION

The conference is being held at the Sheraton City Centre in Salt Lake City, Utah. Participants may make hotel reservations by contacting the Sheraton City Centre at 801-401-2000. A special rate of $119.00 is being offered to conference attendees. Please make your reservation by September 12, 2005 to take advantage of this rate and to ensure availability of rooms.

COURSE DESCRIPTIONS

WEDNESDAY AND THURSDAY, OCTOBER 12 AND 13, 2005 – PRE CONFERENCE COURSES

(Note: These are 2 day courses)

The Management of Cervical Disorders: A Multimodal Approach of Manual Therapy and Therapeutic Exercise 8:00 am – 5:00 pm
Presenter: Gwendolen Jull MPhty, PhD, FACP

Technical Expertise Development in Upper Quarter Manipulation 8:00 – 5:00 pm
Presenter: Jim Meadows BSc.PT., Adv Dip Man Ther.

Residency/Fellowship 101: Everything You Need to Know to Develop and Credential a Residency and Fellowship Program (1 day course) 8:00 – 5:00 pm

Presenters: Stephania Bell, PT, OCS

Rob Landel, PT, DPT, OCS, CSCS

Patricia McCord, PT, FAAOMPT

CONFERENCE PROGRAM

FRIDAY, OCTOBER 14, 2005

The Challenge of Whiplash Associated Disorders

.Presenter: Gwendolen Jull, MPhty, PhD, FACP

Serious and Unusual Pathologies Following Whiplash and their Clinical Recognition

Presenter: Jim Meadows

SATURDAY, OCTOBER 15, 2005 – BREAKOUT SESSIONS

The Diagnosis of Cervicogenic Headache

Presenter: Gwendolen Jull, MPhty, PhD, FACP

Reflex Activation and Deactivation of Dysfunctional Muscle: Some Clinical Observations and Demonstrations and some Speculation

Presenter: Jim Meadows

Positional Faults of the Upper Quarter Leading to Myofascial Dysfunction

This is an intermediate course designed for manual therapists with 3 to5 years experience looking for more advanced understanding of upper quarter joint dysfunction resulting in myofascial signs and symptoms. This is a lecture/demonstration presentation, with opportunity for some hands-on experience. Upon completion of the session participants should: understand how mechanoreceptors have a role in producing myofascial trigger point activity in the presence of joint positional faults; recognize and screen for common positional faults of the upper quarter; recognize and screen for common myofascial trigger points of the upper quarter, and relate them to joint dysfunction; apply intermediate to advanced manual therapy techniques to address positional faults and myofascial dysfunction of the upper quarter; relate current literature to examination and treatment of positional faults, providing evidence base for practice.

Presenter: H. James Phillips, PT, OCS, ATC, FAAOMPT

Cervical Spine Exercise Strategies: Mobility and Stability

This seminar is intended to provide an understanding of the appropriateness of cervical spine therapeutic exercise based on direction of preference and concepts of stability. Examination and exercise techniques will be presented in a lecture and laboratory format. The related evidence regarding cervical spine end range repeated movements and stabilization will be presented throughout the seminar. Appropriate lab attire is required. At the conclusion of the course, the attendee will be able to understand the anatomy, biomechanics, and arthrokinematics of the cervical spine; interpret the appropriateness of upper cervical stability tests and tests for vertebrobasilar sufficiency; analyze patient responses to repeated end range cervical motions to determine appropriateness of exercises based on direction of preference; evaluate the cervical spine to determine the presence of hypermobility and instability; apply appropriate exercise recommendations to improve cervical spine mobility and stability.

Presenter: Ron Schenk PT, PhD, OCS, Cert. MDT, FAAOMPT

A Rationale for Exercising the Patient with Chronic Upper Quarter Dysfunction

Chronic pain patients are on a predictable, destructive and costly path of accelerated poor health and degeneration. Orthopedic Manual Therapists are uniquely positioned to play a key role in the management of this challenging patient population. Due to Manual Therapy's focus on evaluating and addressing the patient's presentation specifically, it is common that the widespread effects of a chronic condition are underemphasized during treatment. This costly mistake is facilitated by the managed care mindset that is prevalent today. The objective of this presentation is to increase awareness of the diffuse changes that occur with chronic conditions and the effective treatment strategies that Manual Therapist can incorporate into their treatment plans. The presentation will review

the current information pertaining to the effects of pain, social isolation and the sedentary lifestyle common to chronic pain patients. Management strategies to counteract these effects will be discussed. The emphasis will be on patient education, participation and responsibility through a well designed exercise program. Special considerations and techniques for protecting local pathology and restoring motor function in the upper quarter will be demonstrated. The goal of the presentation is the enhance the physical therapist's 1) contribution in assisting the medical community in treating this difficult patient population 2) effectiveness in facilitation a real change in the patient's overall presentation 3) ability to restore quality to the patient's life. This presentation will be informative and productive for therapist at all levels of development. It results from our 25 (+) years of study and practice. The presentation will be detailed, yet comprehensible.

Presenters: Tim McGonigle, PT and Michael J. Moore, PT

Radiographic Imaging of the Cervical Spine and Upper Quarter: How Can Radiographic Imaging Inform and Improve Diagnosis and Treatment of the Cervical Spine and Shoulder?

This course will review both the theory behind radiographic imaging and the anatomy of the cervical spine and shoulder as it is displayed radiographically. A systematic approach aimed at critically analyzing images of these regions will be presented, followed by the review of actual images using this approach. Clinical correlations will be discussed in the context of each image. This course will be designed for clinicians with a variety of levels of understanding and will be appropriate as an introductory experience but will also add depth to the understanding of those who have more experience in this task.

Presenter: Tamara L. Little, PT, DMT, FAAOMPT

Navigating Successfully through the Fellow Renewal Process

This course will describe the rationale for the fellow renewal criteria, identify specific components that will meet the Fellow renewal criteria within each section, identify the appropriate resources that can assist with the application process, discuss the renewal timeline and how it applies and how to complete the fellow renewal application.

Presenters: Catherine E. Patla, PT, DHSc, MMSc, OCS, MTC, FAAOMPT

Bob Rowe, PT, DMT, MHS, MOMT, FAAOMPT

IFOMPT EC Americas: Building Education Bridges between CAMPT and AAOMPT

Participants in this workshop will help construct the foundation of a relationship between AAOMPT, CAMT (the Canadian Academy of Manipulative Therapists), and other manual therapy groups in North/South Americas aimed at improved educational encounters, communication between educational groups, and other common goals. The aim is to brainstorm ideas which will forward this project, helping to shape the direction of manual physical therapy nationally, regionally, and globally."

Presenter: Michael Ritchie, President IFOMPT

11th. AAOMPT Conference
Sheraton City Centre, Salt Lake City , Utah, October 14-16, 2005

Membership Dues only $95 per year

(One registrant per form) - **PRINT OR TYPE**

AAOMPT Member No. _____ Name to be Used for Badge _____
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Guest Name, if registered _____

Check if you are:
o AAOMPT Member
o Manual Therapy Resident
Member
o Military
o Committee Chair
o Non Member
o Check here if you are differently abled and may require special accommodations.

	Member Early Bird (Deadline 9/9/05)	Member On-Site (subject to availability)	Non-Member	OMPT Resident (Deadline 9/9/05)
Pre-Conference-*Bell, Landel, McCord*	o $160	o $175	o $220	o $140
Pre-Conference-*Meadows*	o $320	o $350	o $450	o $280
Pre-Conference-*Jull*	o $300	o $325	o $405	o $260
Full Conference	o $415*	o $450*	o $565*	o $360
Pre & Full Conference-*Bell, Landel, McCord*	o $530	o $575	o $715	o $460
Pre & Full Conference-*Meadows*	o $675	o $735	o $915	o $585
Pre & Full Conference -*Jull*	o $650	o $710	o $885	o $570
Guest (Friday-Sunday)	o $ 60	o $ 65		

* O **New grads (2005) students will receive a 50% discount** ** O First 50 entry level students attend Saturday breakout sessions free.

Hotel Information: The conference is being held at the Sheraton City Centre in Salt Lake City, Utah. Participants may make hotel reservations by contacting the hotel at **801-401-2000.** A special room rate of **$119.00** is being offered to conference attendees. Please make your reservations by **September 12, 2005** in order to take advantage of this rate and to ensure availability of rooms.

Method of Payment: Paying by credit card?

Please check one: o MasterCard or o Visa
Card No._____Exp. Date_____
Print Cardholder's Name_____
Signature_____

PLEASE NOTE: Early bird registrations must be post-marked by September 9, 2005. After September 9, 2005 you must pay the on-site registration fees.

Cancellation requests received before September 9, 2005 will be refunded in full. A 20% handling charge will be assessed for cancellation requests post-marked between September 9 and October 7, 2005. No refunds after October 7, 2005. Cancellation requests must be made in writing.

Register by mailing this form, with either credit card information or check payable to AAOMPT to:

AAOMPT
2104 Delta Way, Suite 7
Tallahassee, FL 32303

FAX your registration to: 850/222-0342
or print out a registration form on the internet www.aaompt.org
Questions? Call 850/222-0397

Please check your choice below for breakout sessions you would like to attend.

Breakout Session "1"
8:30 - 10:00 am
- **Gwen Jull**
The Diagnosis of Cervicogenic Headache
- **Michael Moore/Tim McGonigle**
Chronic Upper Quarter Dysfunction
- **Ron Schenk**
Cervical Spine Exercise Strategies
- **James Phillips**
Positional Faults of the Upper Quarter

Breakout Session "2"
10:30 - 12:00 pm
- **Michael Moore/Tim McGonigle**
Chronic Upper Quarter Dysfunction
- **Gwen Jull**
The Diagnosis of Cervicogenic Headache
- **Michael Ritchie**
IFOMPT EC Americas
- **Jim Meadows**
Reflex Activation & Deactivation of Dysfunctional Muscle

Breakout Session "3"
1:00 - 2:30 pm
- **Ron Schenk**
Cervical Spine Exercise Strategies
- **Tamara Little**
Radiographic Imaging of Cervical Spine
- **Gwen Jull**
The Diagnosis of Cervicogenic Headache
- **Jim Meadows**
Reflex Activation & Deactivation of Dysfunctional Muscle

Breakout Session "4"
3:00 - 4:30 pm
- **Standards Committee**
Navigating through the Fellow Renewal Process
- **Ron Schenk**
Cervical Spine Exercise Strategies
- **Michael Moore/Tim McGonigle**
Chronic Upper Quarter Dysfunction
- **Jim Meadows**
Reflex Activation & Deactivation of Dysfunctional Muscle

NAIOMT Course Schedule 2005

NAIOMT 500 LEVEL I DIFFERENTIAL DIAGNOSIS

Location	Dates	Instructor(s)
Portland, OR	Apr 29-May 1 & May 20-22 '05	Hoke
Berrien Springs , MI	May 15-20 '05	Pettman
Burbank, CA	Aug 13-14 & 27-28**10 hr days	Temes
Denver, CO	Sep 15-20 '05	Stupansky
Dallas, TX	Sep 23-25 & Oct 14-16 '05	Meadows/Molloy
Metro Wash. D.C.	Sep 9-11 & Sep 30-Oct 2 '05	Temes
Spokane, WA	Sep 16-18 & Nov 18-20 '05	Allen
Des Moines, IA	Sep 28-Oct 3 '05	Pettman
Seattle, WA	Sep 23-25 & Dec 09-11 '05	Temes
Berrien Springs, MI	Oct 16-21 '05	Pettman
Croton, NY	Oct 21-23 & Nov 18-20 '05	Roy
Portland, OR	Nov 11-13 & Dec 02-04 '05	Temes

NAIOMT 600 LEVEL II INTERMEDIATE UPPER QUADRANT

Location	Dates	Instructor(s)
Seattle, WA	Apr 15-17 & May 13-15 '05	Dobbs
St. Louis, MO	Jul 15-17 & Aug 5-7 '05	Meadows
Portland,OR	Sept 09-11 & Oct 14-16 '05	Keyser
Berrien Springs, MI	Oct 9-14 '05	Pettman
Warren, MI	Oct 21-23 & Oct 28-30 '05	Meadows
Spokane, WA	Oct 21-23 & Dec 2-4 '05	Allen
Denver, CO	Nov 03-08 "05	Molloy
Boise, ID	Oct 28-30 & Nov 18-20	Pettman

NAIOMT 610 LEVEL II INTERMEDIATE LOWER QUADRANT

Location	Dates	Instructor(s)
Spokane, WA	Mar 18-20 & Apr 22-24	Allen
Portland, OR	Apr 8-10 & May 13-15 '05	Temes
Berrien Springs. MI	May 8-13 '05	Pettman
Seattle, WA	Sep 16-18 & Nov 11-13 '05	Dobbs
Portland, OR	Oct 28-30 & Nov 18-20 '05	Temes

NAIOMT 700 LEVEL III ADVANCED UPPER QUADRANT

Location	Dates	Instructor(s)
Spokane, WA	Mar 11-13 & Apr 8-10 '05	Hoke
Portland, OR	Mar 18-20 & Apr 22-24 '05	Pettman
Berrien Springs, MI	Apr 3-8 '05	Pettman
Warren, MI	Apr 8-10 & Apr 15-17 '05	Meadows
Metro Wash. D.C.	Apr 1-3 & Apr 22-24 '05	Meadows
Denver, CO	Oct 13-18 '05	Stoot

NAIOMT 710 LEVEL III ADVANCED LOWER QUADRANT

Location	Dates	Instructor(s)
Seattle, WA	May 27-29 & Jun 24-26 '05	Pettman
Portland, OR	Oct 7-9 & Nov 4-6 '05	Hoke
Berrien Springs, MI	Sep 11-16 '05	Pettman
Metro Wash. D.C.	Nov 4-6 & Dec 2-4 '05	Meadows

NAIOMT 800 ADVANCED SPINAL TECHNIQUES**

Location	Dates	Instructor(s)
Berrian Springs, MI	Apr 10-15 '05	Pettman
Eugene, OR	Apr 15-17 & May 13-15 '05	Hoke
Berrien Springs, MI	Sep 18-23 '05	Pettman

**Prerequisite: successful completion of NAIOMT Level III Case Studies, Written Exam, and pre-course assessment. (or equivalent

SPE**CIALTY COURSES**

Location	Course	Dates	Instructor(s)
Portland, OR	NAI 625 Peripheral Manipulation	Jun 03-05 '05	Hoke
Boise, ID	Lumbopelvic/Lower Limb	Jun 10-12 '05	Lee
Tulsa, OK	NAI 770 Acute MVA	Aug 26-28 '05	Meadows
Portland, OR	NAI 720 Reasoning in DDx	Sep 24-26 '05	Pettman
Seattle, WA	NAI 625 Peripheral Manipulation	Sep 30-Oct 02 '05	Hoke
Berrien Springs, MI	NAI 770 Acute MVA	Oct. 02-04 '05	Meadows
Warren, MI	NAI 775 Dizz/Headach	Oct 07-09 '05	Meadows

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Average cost per course day is $160.00
Cost will vary by location.
All NAIOMT courses are organized and managed on a local level.
For details on the courses and registration go to NAIOMT's web site at www.naiomt.com

Don't curse the darkness, light a candle.

Editor Jim Meadows

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HAVE A GREAT SUMMER EVERYONE

DVD Price Change Notification

The subscriber and NAIOMT discount of 50% off the full price of $700 for the DVD series Manual Therapy by Jim Meadows will be available until the end of August after which the discount will be reduced to 40% for a price of $420. Past students of mine may still received the 50% discount and the Canadian dollar is still accepted at par with the US dollar.

The MVA video is available alone for $70. See page 6 of this issue for a pretty picture but for further information on the content of the video see my web site.

For ordering information email me at either jmeadowspt@aol.com or jim@swodeam.com