For every physio who cares

Hands on

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Please send any text in a Word or Word-compatible format, to mandiwrite@icon.co.za. Articles should be no longer than 2000 words, ideally, and no shorter than 300. Please send pictures digitally to wkat@midrand-estates.co.za if at all possible. Don’t send them as an integral part of a Word document, though; send them separately, ideally as a Jpeg file. Try to keep the attachments smaller than 6.5 meg per e-mail, zip them if needed or send separate e-mails.
Painful news

Y ears ago, I discovered that it was not a good idea to talk about a pain condition, not even to medical practitioners, because if there is no easily identifiable cause for it, it makes them feel helpless – and a helpless GP, in my experience, is one who reaches for his RX pad to write you a script for an anti-depressant!

A frustrated chronic fatigue syndrome (CFS) patient wrote to me once, tongue firmly in cheek:

“Depression and other psychiatric or mental illnesses protect one against ALL physical illnesses. Therefore, it is impossible to have a physical illness if you have depression. All of us with CFS should just get depressed so that we will no longer suffer from any physical illnesses.

“Also, 90% of all physical illnesses can be cured by either losing weight or stopping smoking. So if you suffer from grave physical illness, and you either smoke or need to lose weight, all you have to do is sign up for a weight-loss programme or a stop-smoking programme, follow it closely, and you will be cured.”

Which beautifully encapsulates the common experience of people with difficult-to-diagnose and or treat problems. It’s all in your head/if you lost some weight/smoking is bad for you, you know.

Well, it looks as though I may be on the road to some pain relief at last, in the form of a small operation.

And some recent research that crossed my desk holds out the promise of relief for those most difficult of pain patients, those with Complex Regional Pain Syndrome:

Scientists at the University of Liverpool have discovered that treating the immune system of patients with Complex Regional Pain Syndrome (CPRS) leads to a significant reduction in pain.

CPRS is an unexplained chronic pain condition that usually develops after an injury or trauma to a limb, and continues after the injury has healed. CPRS I — formerly called Reflex Sympathetic Dystrophy — can arise after any type of injury. CPRS II, previously called causalgia (a term coined in the American Civil War when it was first diagnosed), follows partial damage to a nerve. In some cases the pain can be so severe that patients request amputation, only to find that the pain returns in the stump.

CPRS pain can improve within one year after the injury, but if it is still unchanged after 12 months (long-standing CPRS), then it will often not improve at all. Longstanding CPRS affects about 1 in 5,000 people in the UK.

The team at the Pain Research Institute discovered that a single, low dose infusion of intravenous immunoglobulin (IVIG) significantly reduced pain in just under 50 per cent of patients treated, with few adverse effects. The pain relief lasted on average 5 weeks. The results of this study may change the future treatment of patients with CPRS, and have an impact on research in other severe chronic pain areas.

(From ScienceDaily, 7 February 2010. The research is published in the journal Annals of Internal Medicine.)

And here’s another little bit of recent research that I found interesting — having experienced the psychological consequences of persistent pain:

The anxiety that often accompannies a chronic illness can chip away at quality of life and make patients less likely to follow their treatment plan. But regular exercise can significantly reduce symptoms of anxiety, a new University of Georgia study shows.

In a study appearing in the 22 February edition of the Archives of Internal Medicine, researchers analyzed the results of 40 randomized clinical trials involving nearly 3,000 patients with a variety of medical conditions. They found that, on average, patients who exercised regularly reported a 20 percent reduction in anxiety symptoms compared to those who did not exercise.

“Our findings add to the growing body of evidence that physical activities such as walking or weight lifting may turn out to be the best medicine that physicians can prescribe to help their patients feel less anxious,” said lead author Matthew Herring, a doctoral student in the department of kinesiology, part of the UGA College of Education.

Herring pointed out that while the role of exercise in alleviating symptoms of depression has been well studied, the impact of regular exercise on anxiety symptoms has received less attention. The number of people living with chronic medical conditions is likely to increase as the population ages, he added, under-scoring the need for a low-cost, effective treatment.

(From ScienceDaily 28 February, 2010)

Nice ammo for any of you trying to get people with chronic conditions to get moving. And two wonderful steps forward for people suffering from hard-to-treat pain and illness!
Time for a change!

President Magda Fourie on how your physio magazine will be changing over the next few issues

Fasten your seatbelts, pour yourself a nice cup of coffee, sit back and enjoy the new Hands On magazine! You have guessed correctly, Hands On will no longer be the familiar ‘newsletter-style’ magazine, but instead is evolving into an interesting magazine for physiotherapists, which we envisage will be relevant and interesting for other health professionals in the future.

The shape of communications is changing, and the communications team understands this. Print media are no longer the way to communicate news that needs to be auctioned immediately – such as changes to coding – this is more efficiently done through the digital media, like SMS and e-mail. On the other hand, physiotherapists are human beings with normal everyday problems such as stress, naughty children, financial constraints, the need to buy a new car, or to go on holidays. Our new format will cover many aspects of your life and practice.

The concept will cover:

**Your professional life**: information such as how to run your business effectively, legal information, how to handle your staff, are you insured, what will happen to you at retirement, what to expect from your community service year, and the like. Please continue to send your news from the Provinces, Special Interest groups and National Physiotherapy BackWeek if it could be of interest to all of us – we can all learn lessons from how other physios tackle marketing, for instance.

**Your health**: general health information that you need to be aware of but that is either not scientific enough for the SASP Journal, or not physio-focused. Mandi has touched on a few topics recently, for example in her article titled ‘Fat chance’.

**The environment in which you practice**: topics such as National Health Insurance (NHI), Reference Price List, Consumer Act, Protection of title, climate change, social development, government policy and other relevant information which we need to understand to ensure the future of physiotherapy in South Africa.

**Your personal life**: I am sure you will enjoy this section as we will get experts to give advice on children and teens, education, stress relief (yes, we also need that!), time management, balancing work with pleasure, relationship challenges and much more.

Important news and information our members need to act on immediately or be aware of will be sent via electronic media, e.g. 4U2NO, Coding Clown and general bulk emails, Facebook or via the SASP website: www.physiosa.org.za.

As the saying goes: ‘A change is as good as a holiday’. I certainly hope you will enjoy this holiday as part of the new dynamic and pro-active Society.

**KE NAKO – 70 days to the Fifa Soccer World Cup!**

President

Please Note that the phone numbers at Head Office changed AGAIN!

Tel: (011) 615-3170/80

We apologise for the inconvenience and thank you for your patience during this frustrating time
SA’s New Health Care Plan

This email is currently doing the rounds (we’ve slightly adapted it to avoid offending some people!):

The South African Medical Association has weighed in on the new health care plan being developed by the Zuma team.

The Allergists voted to scratch it, but the Dermatologists advised not to make any rash moves.

The Gastroenterologists had sort of a gut feeling about it, but the Neurologists thought the Administration had a lot of nerve.

The Obstetricians felt that they were labouring under a misconception.

Ophthalmologists considered the idea short-sighted.

Pathologists yelled, “Over my dead body!”, while the Paediatricians said, “Oh, grow up!”

The Psychiatrists thought the whole idea was madness, while the Radiologists could see right through it.

Surgeons decided to wash their hands of the whole thing. The Internists thought it was a bitter pill to swallow.

And the Plastic Surgeons said, “This puts a whole new face on the matter”.

The Podiatrists thought it was a step forward, but the Urologists were p-eed off at the whole idea.

The Anaesthesiologists thought the idea was a gas, and the Cardiologists didn’t have the heart to say no.

In the end, the Proctologists won out… it’s a job for a bunch of a-holes, after all.

PhysioFocus making a difference!

Teddies were distributed at Parklands Hospital to cancer patients.
Physiotherapists loom large in the lives of ballet dancers, who make enormous demands of their limbs daily. The rate of injury in professional dancers is 67-95 percent.

Chase Botha was in love with the study of human anatomy and physiology even before he started training as a dancer in 1989 with Noreen Nelson, but after that, ballet began to assume an ever-larger role in his life.

By 2004 Chase was accomplished enough to be accepted onto The South African Ballet Theatre’s Graduate Programme, performing the roles of the Peasant Pas de Deux in Giselle, the Neapolitan Dance in Swan Lake, Jester in Cinderella and the Rat King in The Nutcracker.

In 2004, Chase appeared as a guest artist with the Johannesburg Youth Ballet, the North West Youth Ballet and the Buffalo City Youth Ballet appearing in the title roles of JYB’s La Sylphide and Coppelia in East London and The Prince in the North West Youth Ballet’s Cinderella.

In 2005 he was accepted into the South African Ballet Theatre (SABT) as a member of the corps de ballet and promoted to Senior Corps de Ballet in 2006.

His roles with the SABT have included the Russian Dance and Spanish Dance in The Nutcracker, Puss in Boots in The Sleeping Beauty, Spanish dance and Pas de Trois in Swan Lake (2007) Mercutio in Romeo & Juliet Sancho Panza in Don Quixote, the Jester and Ugly Sister in Cinderella-the Ballet and Franz in Coppélia.

Chase appeared in the broadcast of Swan Lake on SABC 2 in December 2007 and in 2009, Chase made his debut as Hilarion in Giselle at the Joburg Theatre.

Body work
But ballet alone was not enough to fulfil all Chase’s needs – he still had that passion for the human body. In 2008, after a one-year course, Chase qualified as a registered sports massage therapist. “I have always loved to give massages,” he says, “and I thought, why not learn how to give a proper massage?”

Today he is much in demand by his fellow dancers, whom he treats at the Civic Theatre. “Common injuries among dancers affect the whole leg up to the hip,” he says. “I also have a lot of clients with back problems. This is especially the case in the male dancers – in the lifts, the back and arms take a lot of strain.”

He spends some of his time helping dancers understand how they can prevent injury. “Everyone expects sports massage just to be the massage, but I also teach them about stretching and give them strengthening exercises – often injuries result from weak abdominal muscles, for example. You have to go to the source of the problem.”

Chase intends to continue doing sports massage therapy – his life plan is to set up his own practice and study further, so that he can make a business of this when the time comes, as it does for all dancers, for his professional involvement in ballet to decrease.

Chase himself consults a physio whenever he needs one, of course!

April 2010 Hands On
“An investment in key person insurance could offer a physiotherapy practice financial protection and peace of mind in the event of losing a key employee. In fact, such an investment could provide the necessary funds to overcome any negative impact that could result from the disability or death of a key person,” says Koos Nel, marketing manager (personal financial advice) at Old Mutual.

The dilemma of losing a key person
The loss of a key person in a practice could result in a number of financial challenges such as a slowdown in turnover, decline in profitability or sales, stricter terms from suppliers, difficulty in raising finance, loss of expertise or a delay in finding a successor – to mention just a few possible impacts. “Apart from threatening your profitability, the loss of a key person may also affect the continuity or sustainability of a practice,” Nel adds.

Who is the key person in your practice?
A key person is defined as anyone who significantly improves the profitability and effective management of a practice. For example:
• A specialist with professional skills vital to the sustained success of a practice;
• An employee that attracts and retains competent staff; or
• A staff member whose presence enhances the creditworthiness of a practice directly or indirectly, or who plays a significant role in building goodwill.

How does key person insurance work?
The practice insures the life of a key employee for the purpose of compensating the business for the loss of income that it would suffer in the event of that employee becoming disabled or passing away. It is important to note that these premiums are paid for by the business or practice.

Upon the disability or death of a key person, the proceeds from the key person insurance can be used to absorb financial disruptions to the practice and/or to provide funds to recruit and train a suitable replacement.

Determining the value of a key person
Although there are various ways of determining the value of a key person, the recommended method involves the following calculations:
• The actual cost of replacing the key person;
• The key person’s worth to the business in terms of net profits;
• The cost to the business if the key person were to become disabled or die;
• The degree to which the business wishes to protect itself against the loss that would be sustained when losing the key person.

Adequate cover is essential
Investing in adequate cover will ensure that there will be cash available:
• For recruitment and/or training of new employees;
• To ensure the continued existence and development of the practice;
• To safeguard existing contracts;
• To protect the creditworthiness of the practice.

It is also important to bear in mind that should the key person insurance contract be structured that the benefit payment is fully taxable in the hands of the employer, the amount of cover purchased should be increased.

/about-the-author
Koos Nel is an expert on key person insurance at Old Mutual.
E-mail him at knel1@oldmutual.com for more info.
Dr Ina Diener came across this letter written by a well-known physiotherapist in Ontario to his physiotherapy society. “We would like to get your comments on this,” she says. Please write to Hands On (see contents page for addresses) and give your opinion.

Dear Ontario Physiotherapy Association

I must confess that I was disappointed in seeing the advertisement of the ‘Energy Therapy Course’ in the January 2010 Issue of Physiotherapy Today.

I regrettably attended the ‘energy’ course you have advertised, back in 2005. I must inform my colleagues and my Professional Association that the courses are a true shame to have associated with our profession. The three PTs on the course (including myself) requested for a tuition refund upon completion of the course, due to the ‘inappropriate nature’ of the course.

The physiotherapy profession has worked so hard in the past decades to become University based and part of the Faculty of Medicine. We cherish our strong focus on research, PhDs, clinical trials and Evidence-Based practice. Fortunately we have succeeded a fair bit, although we still have long ways to go, as does the rest of medicine.

There are hundreds of evidence-based physiotherapy research studies published in highly respectable peer reviewed journals. Physiotherapy interventions such as mobilisations / manipulations, specific exercise prescription, acupuncture, Mulligan mobilisation concepts, cognitive behavioural therapy, pain education, eccentric exercises, aerobic training, etc. etc. have all shown substantial clinical efficacy.

However, courses such as ‘energy healing’ or ‘light-touch healing’ help destroy the reputation we have worked so hard to achieve. The assessment involves, floating your hands over the patient and feeling for ‘weak energy fields’. The treatments also involve floating of the hands over the patient and ‘re-aligning energy’ by applying light ‘bouncy energy pressures’ over the liver or kidney or the cranium to effect right ankle pain for example, with preposterous claims that bone shape is changed within one single session.

I am not against other health care professionals performing these techniques, it may even be true that alternative treatments such as therapeutic touch, Reiki or Aromatherapy may genuinely work, but I find it very disturbing when these methods are promoted to and practiced by physiotherapists. Physiotherapists have so many EVIDENCE-BASED methods of helping patients that do not involve floating of hands and feeling energy fields of patients’ pancreas.

I am extremely proud of my profession and our accomplishments and sincerely wish to protect us from taking ‘backward steps’.

Ruti Katz can be contacted on: 082 558 6804

Medical practitioners can ensure that they focus on their billing potential; reduce the risk of bad debts by decreasing the time frame for collection from patients and medical aids; and improve cash flows, while staying focused on their patients’ needs, by outsourcing the management of their medical revenue management to a specialist administrator.

Says Ruti Katz of The Bureau, a medical revenue management agency in Johannesburg: “Some medical practitioners are weighed down by more than R500 000 in unpaid medical aid claims, which accumulates to around 20 percent of their monthly turnover, with most debtors in excess of 30 days. This, along with taxation on their turnover, erodes their profit and cash flow, putting their business into the danger zone.”

“One of the main causes of failure for many practices is not managing their cash flow, or knowing where the source of 80 percent of their revenue comes from – which is often from just 20 percent of their patients.

“The bottom line is what gets measured, is what improves. Most businesses don’t measure in as much detail as they should because measurement requires work and a lot of thinking, but it is worth it because it allows you to make the right decisions.”

Says Charlene Brett, a speech and hearing therapist with over twenty years’ experience in treating adults and children, both for corporates and in private practice: “What concerned me, as a practitioner, was that I didn’t have the time or skills to ensure the regular follow up required to guarantee prompt and safe payment from the medical aids for outstanding accounts. I know what I am good at, and it’s not accounts.”

“Before I outsourced the administration of my business, I found it difficult to be the caring interface between the patient and my practice as well as demanding payment from them on a monthly basis.”

“Outsourcing freed me up to service my clients, ensuring the confidentiality that they require, without disrupting our relationship. I no longer needed to be anxious about whether my business was sustainable, I knew I was in good shape.”

Most sole practitioners find it particularly difficult to collect fees, but joint practices are often plagued with inefficient or untrained staff, no credit vetting of patients or confirmation of who is responsible for payment of the account, whether private or from workman’s compensation, which all leads to ineffective claims processing in the administrative cycle.

Ruti Katz can be contacted on: 082 558 6804
Hands On

April 2010

Farewell and thank you

The South African Physiotherapy Profession mourns the passing of an outstanding physiotherapist.
Dr Ina Diener reflects on his achievements

Born in South Australia, Mr Maitland pioneered manual therapy in Australia. He trained as a physiotherapist at the University of Adelaide and later became a clinical tutor at the South Australian physiotherapy school. Around this time he began to develop a special interest in the treatment of musculoskeletal disorders of the spine, and over time he became an international authority on the subject. He studied and travelled widely, and compiled knowledge from a wide variety of sources. He also made numerous first-hand clinical observations. As a result of all this he devised his own ‘Maitland’ approach to manipulation which was subsequently adopted across the profession. South African physiotherapists followed his approach since then.

He was one of the cofounders, in 1974, of the International Federation of Orthopaedic Manipulative Physical Therapists (IFOMPT), a branch of the World Confederation for Physical Therapy (WCPT). His commitment to the physiotherapy profession, innovation, professional and academic success have all become cornerstones of modern physiotherapy practice.

Geoff Maitland passed away peacefully on Friday January 22nd 2010 aged 86.

The Orthopaedic Manipulative Physiotherapy Group of the South African Society of Physiotherapy was sad to hear of the death of Geoff Maitland. We extend our deepest sympathy to his family.

Physiotherapy in South Africa has benefited immensely from his visits and expertise in Orthopaedic Manual Therapy.

We, together with you, thank Geoff for his friendship, skill and mentorship which so greatly enriched our professional lives as physiotherapists.

Dr Ina Diener
For the Orthopaedic Manipulative Physiotherapy Group of South Africa
THE EFFECTS OF COMPRESSION GARMENTS ON RECOVERY OF MUSCLE PERFORMANCE FOLLOWING HIGH-INTENSITY SPRINT AND PLYOMETRIC EXERCISE

Rob Duffield, Jack Cannon, Monique King

Abstract
This study compared the effects of compression garments on recovery of evoked and voluntary performance following fatiguing exercise. Eleven participants performed 2 sessions separated by 7 days, with and without lower-body compression garments during and 24 h post-exercise. Participants performed a 10-min exercise protocol of a 20-m sprint and 10 plyometric bounds every minute. Before, following, 2 h and 24 h post-exercise, evoked twitch properties of the knee extensors, peak concentric knee extension and flexion force were assessed, with blood samples drawn to measure lactate [La−], pH, creatine kinase (CK), aspartate transaminase (AST) and c-reactive protein (C-RP). Heart rate, exertion (RPE) and muscle soreness (MS) measures were obtained pre- and post-exercise. No differences (P = 0.50–0.80) and small effect sizes (d < 0.3) were present for 20-m sprint (3.59±0.22 vs. 3.59±0.18 s) or bounding performance (17.13±1.4 vs. 17.21±1.7 m) in garment and control conditions. The decline and recovery in concentric force were not different (P = 0.40) between conditions. Full recovery of voluntary performance was observed 2 h post-exercise, however, evoked twitch properties remained suppressed 2 h post-exercise in both conditions. No differences (P = 0.40–0.80, d <0.3) were present between conditions for heart rate, RPE, [La−], pH, CK or C-RP. However, 24 h post-exercise a smaller change (P = 0.08; d = 2.5) in AST (23.1±3.1 vs. 26.0±4.0) and reduced (P = 0.01; d = 1.1) MS (2.8±1.2 vs. 4.5±1.4) were present in the garments. In conclusion the effects of compression garments on voluntary performance and recovery were minimal; however, reduced levels of perceived MS were reported following recovery in the garments.

IS ILIOTIBIAL BAND SYNDROME REALLY A FRICTION SYNDROME?

John Fairclough, Koji Hayashi, Hechmi Toumi, Kathleen Lyons, Graeme Bydder, Nicola Phillips, Thomas M. Best and Mike Benjamin

Summary
Iliotibial band (ITB) syndrome is regarded as an overuse injury, common in runners and cyclists. It is believed to be associated with excessive friction between the tract and the lateral femoral epicondyle-friction which ‘inflames’ the tract or a bursa. This article highlights evidence which challenges these views. Basic anatomical principles of the ITB have been overlooked: (a) it is not a discrete structure, but a thickened part of the fascia lata which envelops the thigh, (b) it is connected to the linea aspera by an intermuscular septum and to the supracondylar region of the femur (including the epicondyle) by coarse, fibrous bands (which are not pathological adhesions) that are clearly visible by dissection or MRI and (c) a bursa is rarely present—but may be mistaken for the lateral recess of the knee. We would thus suggest that the ITB cannot create frictional forces by moving forwards and backwards over the epicondyle during flexion and extension of the knee. The perception of movement of the ITB across the epicondyle is an illusion because of changing tension in its anterior and posterior fibres. Nevertheless, slight medial–lateral movement is possible and we propose that ITB syndrome is caused by increased compression of a highly vascularised and innervated layer of fat and loose connective tissue that separates the ITB from the epicondyle. Our view is that ITB syndrome is related to impaired function of the hip musculature and that its resolution can only be properly achieved when the biomechanics of hip muscle function are properly addressed.

After action
Dr Linda Steyn offers some new research on compression garments and the ITB
Delegates attending the forthcoming WCPT Congress, to be held in Amsterdam next year, will have a new flexibility in selecting which sessions to attend to suit their needs best. The programmes within the congress, and in related activities, are being dovetailed so that delegates can select a combination of scientific sessions, such as focused symposia and discussion sessions, practical courses and visits, all within their area of interest.

There will also be the full congress package that past delegates will be used to. Tracy Bury, WCPT’s Professional Policy Consultant, likens the new approach to “pick and mix” sweet/candy stalls – where customers grab a bag and fill it with a selection of their favourite confectionary. She has been working closely with the International Scientific Committee on planning a programme that will appeal to as many clinicians, researchers, educators and managers as possible, and allow them to use their time at the congress to more effectively meet their interests.

“It’s designed to allow delegates to build anything from a two-day to a five-day portfolio of activities embracing the scientific programme and more practical or issue-based activities,” she said. The main details of the programme, including the focused symposium subjects and presenters, are announced this month [February – check www.wcpt.org for details]. In June, the satellite programme’s workshops and courses will be announced.

How will it work?
Imagine you are a physical therapist working in paediatrics in a general hospital, who has three days to spend at the congress, and wants to find as much information as possible to improve everyday practice. The main scientific programme will include focused symposia that have been challenged to identify the implications of research for the everyday practice of clinicians, managers, educators and policy makers.

There will be other types of session in the main scientific programme – platform papers, posters and discussion panels for example – which will cover topics relevant to a paediatric physical therapist. But there will also be sessions outside the main scientific programme in a satellite programme which will allow new insights into services and practice – through clinical courses for example. A paediatric physical therapist will be able to plan her visit so that she can easily fill three days with a variety of options, for example:

Day 1: Pre-congress course
Day 2: Congress scientific programme – symposia, discussion panels, posters, platform abstracts, exhibition
Day 3: Congress scientific programme

If she registers for the full congress, she will also be able to access the clinical visit options.

“We want people to attend the congress and find sessions on offer that are relevant to their areas of interest and balance scientific knowledge with practical application,” says Tracy Bury. “We also want them to see things that are new and hopefully challenge them to look at their practice in different ways. This may come from some of the professional issues topics that cut across all areas of practice.”
Winter warmers

Mandi Smallhorne raves about super soups

As the mornings start to get chilly, my thoughts turn to soup. I think it’s my favourite dish to make - yummy soup in a deep bowl with a crusty slice of bread.

I found some great recipes in a recent British cook book, in the Best Food Fast! series. This book is called Tasty Vegetarian (Eaglemoss Publications Group), an affordable addition to your cookery shelves and especially good if you want to eat a little less meat and add some vegetarian options to your diet.

Try this:

### Creamy Red Pepper Soup

1. large red pepper, deseeded and cut into thin strips
2. large onion, thinly sliced
3. 2 tablespoons olive oil
4. 2 large beefsteak tomatoes, skinned, deseeded and chopped
5. 1 tablespoon sun-dried tomato purée
6. Finely grated zest and juice of 1 large orange
7. 600 ml vegetable stock
8. Salt and freshly ground black pepper
9. 1 tablespoon single or double cream
10. Ciabatta to serve

Fry the pepper and onion in the oil for 5 minutes, or until soft. Add the tomatoes, tomato purée, orange zest and juice and stock.

Bring to the boil, reduce the heat, cover the pan and simmer gently for about 45 minutes. Cool slightly, then whizz, in batches, in a blender or with a wand blender.

Reheat the soup, season to taste and garnish with a little cream and coarsely ground black pepper. Serve accompanied by warmed ciabatta.

Serves 2

### Lentil and Tomato Soup

1. 1 onion, finely chopped
2. 2 carrots, finely diced
3. 1 tablespoon olive oil
4. 2 garlic cloves, finely chopped
5. 1 teaspoon yellow mustard seeds
6. 3 tomatoes, roughly diced
7. 125 g red lentils
8. 1.25 litre vegetable stock
9. Salt and freshly ground black pepper
10. Tortilla chips and snipped chives, to serve

Fry the onion and carrots in the oil for 5 minutes until soft. Add the garlic and mustard seeds and continue cooking for a further 2 minutes

Stir in the tomatoes, lentils and stock and bring to the boil. Reduce the heat, cover and simmer gently for 30 minutes until the lentils are tender and easy to crush.

Season well and ladle into warm serving bowls. Then serve with warmed tortilla chips and chives.

Serves 4
It’s been a really hard couple of years. In 2008, the economies of the world began to turn turtle; last year, it came close to many of us. Those in private practice may have felt the pinch, but certainly all of us know people – may even be related to people – who have had to take salary cuts, sell assets, experience the trials of retrenchment and the like.

For some reason, many of us also had unrelated stresses last year. I’d become so inured to hearing tales about divorce, death, and health problems that I was thrilled to come across a young woman who had just had a baby and whose worst problem in 2009 was deciding whether to speak Pedi, Shangaan or English to her little girl!

The levels of stress many have experienced in recent months, as you know, can raise the risk of falling ill – stress affects immune response – and experiencing psychological problems.

Very often, people don’t realise they are seriously stressed. This stress test is adapted from one found on www.compassionfatigue.org, but it is very similar to others like it. All of them weight the same top ten to twenty factors in roughly the same way.

Tot up the points for each event and check your score at the bottom.

1. Death of Spouse (100 points)
2. Divorce (73 points)
3. Marital or Relationship Partner separation (65 points)
4. Jail term (64 points)
5. Death of close family member (63 points)
6. Personal injury or illness (53 points)
7. Marriage (50 points)
8. Fired from work (47 points)
9. Marital or Relationship Partner reconciliation (45 points)
10. Retirement (45 points)
11. Change in family member’s health (44 points)
12. Pregnancy (40 points)
13. Difficulties with sex life (39 points)
14. Addition to family – new baby or adopted child or relative who moves in (39 points)
15. Business readjustment or restructuring (39 points)
16. Change in financial status (38 points)
17. Death of close friend (37 points)
18. Change to a different line of work (36 points)
19. Change in number of marital/relationship arguments (35 points)
20. Mortgage or loan over R230 000 (31 points)
21. Foreclosure of mortgage or loan (30 points)
22. Change in work responsibilities (29 points)
23. Trouble with in-laws (29 points)
24. Outstanding personal achievement (28 points)
25. Spouse begins or stops work (26 points)
26. Starting or finishing school (26 points)
27. Change in living conditions (25 points)
28. Revision of personal habits – you take up an exercise programme or drop one, or the like (24 points)
29. Trouble with boss (23 points)
30. Change in work hours/conditions (20 points)
31. Change in residence (20 points)
32. Change in schools (20 points)
33. Change in recreational habits and hobbies (19 points)
34. Change in church activities (19 points)
35. Change in social activities (18 points)
36. Mortgage or loan under R150 000 (17 points)
37. Change in sleeping habits (16 points)
38. Change in number of family gatherings (15 points)
39. Change in eating habits (15 points)
40. Vacation (13 points)
41. Christmas season (12 points)
42. Minor violations of the law (11 points)

Will you be more susceptible to illness as a result of your stress load? There’s no way of saying for sure – all of us have different coping skills – but your score can give a rough guide.

<table>
<thead>
<tr>
<th>Score Range</th>
<th>Susceptibility to Stress-related Illness</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-149</td>
<td>Low susceptibility to stress-related illness</td>
</tr>
<tr>
<td>150-299</td>
<td>Medium susceptibility to stress-related illness: Learn and practise relaxation and stress management skills and a healthy life style.</td>
</tr>
<tr>
<td>300 and over</td>
<td>High susceptibility to stress-related illness: you need to practise relaxation techniques daily, and should seek professional counselling.</td>
</tr>
</tbody>
</table>
Spotlight on Physiotherapy practices

How long have you been in practice?

Wilma Erasmus:  
Since 1978 in Witbank

Wilna-Mari van Staden:  
Three years in Vaalwater, Limpopo

What is the one thing that makes your practice a success?

Wilma Erasmus:  
Three principles:  
- To always practise physiotherapy as perfectly as possible, and based on evidence.  
- Never to lie to a patient  
- Good communication between you and the patient, you and your staff is paramount.

Wilna-Mari van Staden  
Always treat your patients with friendliness and be true in your conduct.

What was your best day in practice?

Wilma Erasmus:  
When I was awarded the National Business Woman of the Year in the professional category in 2008.  
95% of all my days at work are the best, but two weeks ago I had an especially good day when an eleven years old CP girl danced for me in the swimming pool, which had her mom and I in tears.

Wilna-Mari van Staden  
Every day is the best day; if you enjoy your job, you will never have to work a single day in your life.

What was your worst day in the office?

Wilma Erasmus:  
In the beginning of 2009 I suffered from extremely bad cluster headaches for about three months. That made it so difficult to think and concentrate. One day it was so bad that I was almost in tears, but so busy that I just had to go on!

Wilna-Mari van Staden  
I came in having just had a terrible morning, bumped my car, had a misunderstanding with my mother, was soaking wet with rain, really tired with exam stress and late nights working on my protocol. That afternoon, I actually forgot a patient lying on the treatment bed, enjoying his interferential and infrared lamp... I invited the second patient in... luckily I always draw the curtains!

Do you have a role model?

Wilma Erasmus:  
I have a couple:  
- Dr Ina Diener: she is an example of a physio who stays humble despite having achieved so much for physiotherapy in South Africa and abroad.  
- Joy Edeling: I started working for her as a young inexperienced physio; she showed me what good ethics and morality is worth in a business.  
- My late mom, who believed in me and encouraged me to become a physiotherapist, when others told me I would not make it!

Wilna-Mari van Staden  
It is not a person but a concept of the Japanese karate association: this holistic approach combines body, mind and spirit – the whole person must be developed simultaneously. The concept is reinforced by the following five statements and I try each day to strive to perfect them:  
- Seek perfection of character  
- Be sincere  
- Put maximum effort into everything you do  
- Respect others  
- Develop self-control

Please attend the National SASP AGM on 16 April 2010  
Time: 12h00 for 13h00  
Venue: Protea Wanderers Hotel, Corlett Drive, Illlovo, Johannesburg
A patient presented with acute pain on the lateral side of her wrist. She is a dress maker and uses her hand for cutting material. On palpation, there was tenderness over the area. Swelling was also observed and Finkelstein’s test was positive. I diagnosed the injury as an overuse injury called de Quervain’s Tenosynovitis.

The tendons of both Extensor Pollicis Longus and Abductor Pollicis Longus each pass through a synovial sheath at the level of the radial styloid. Continuous hyper-abduction of the thumb creates friction of the sheaths resulting in inflammation of the synovium.

In the case of tenosynovitis, Leukotape K 50mm is applied for space correction. Because of the fascial structure of the body, if the skin is lifted, pressure on the structures below decreases. This allows for an increase in blood supply, an increase in lymph drainage and a decrease in pressure on the mechano-receptors, therefore a decrease in pain.

In order to create this space, Leukotape K must be applied with no stretch at all. The body must be stretched. This will result in convolutions of the tape and a lifting of the skin. Leukotape K 25mm was applied as an adjunct to physiotherapy treatment.

The application of the strapping technique for de Quervain’s tenosynovitis is as follows:

1. The tape is measured for the desired length with the thumb placed in the palm of the hand (Flexion of the MCP and phalangeal joints). Ulnar deviation of the wrist is then added.

2. N.B. As this is placing the tendons on maximum stretch, care must be taken not to create pain and the position may have to be modified.

3. The paper at the top and bottom of the tape is torn to create two 5cm bases.

4. The first 5cm base is applied to the thumb just below the thumb nail and the glue is activated.

5. The tape is now placed along the length of the tendons and the muscles. Once in the correct position, it is rubbed to activate the glue.

6. The lower 5cm base is then applied and the glue is activated. At no time is the tape stretched. The tape must convolute over the radial styloid when the thumb is abducted.

**STRAPPING TIPS: DE QUERVAIN’S TENOSYNOVITIS**

**Muscle cramps: things to consider**

Rob Simms, NEC OMPTG, gives some useful info

Muscle cramps/night cramps/post–exercise cramps can occur in anyone from the elderly to the high level athlete. Although these painful muscle cramps are mostly benign (relieved by simple regular stretching), clinicians must be aware of all the various potential causes of cramps and rule out underlying serious medical conditions.

A number of my patients have been very grateful when I have suggested they see their GP as their meds may be cause of their painful cramps...and I have been right a few times!

**Muscle cramps may be related to:**

1. Early Parkinson’s disease (Look for involuntary trembles, loss of balance – refer to GP)
2. Hypothyroidism (Ask about weight gain, feeling fatigue and cold – refer to GP)
3. Diabetes mellitus (Ask about feeling fatigue, family history of diabetes, unquenchable thirst, frequent trips to the bathroom – refer to GP)
4. Vascular problems (Check pulses and look for general leg coldness and paraesthesia – refer to GP)
5. Electrolyte disorders (Ask about fatigue, dizziness or confusion…urine and blood lab tests required, these individuals need more than a sport drink or a banana!)

**Cramps may also be due to the side-effects of certain drugs:**

1. Lipid–lowering agents (Always ask if they are on any cholesterol lowering medications)
2. Antihypertensives (Always ask if they are being treated for high blood pressure)
3. Beta-agonists (Ask if they take asthma meds or anything for COPD)
4. Oral contraceptives (Ask them to speak with a pharmacist about the potential side effects)
5. Alcohol (Inform them that alcohol may contribute to muscle cramps in some people – regrettably the evening glass of red wine may be the culprit!)

**From the APTEI newsletter**

Rob Sims 
NEC OMPTG

Please forward any queries or comments with respect to injuries, techniques or Leuko products to askleuko@bsnmedical.com for advice from the Leuko Strapping Panel, who are members of the South African Society of Physiotherapy. Selected questions will be loaded onto the BSN Medical website www.bsnmedical.co.za for reference purposes.

Refer to the Leuko Strapping Guide for basic guidelines.

Leuko is endorsed by the SASP