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**Brand Guidelines**

The Brand Guidelines reference book provides more detailed information and suggestions as to what you must do and say to live the brand to promote physical therapy through your daily behavior and interaction.

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**Movement Becomes a Lifelong Pursuit for Those With Disabilities**

By Deb Nerud, BS, MA, NREMTP

Lifelong chronic medical conditions—conditions with a childhood onset that progress into adulthood—are often the hallmark of individuals who have lifelong disabilities (LLD). The physical therapist (PT) can be the expert in addressing issues associated with LLD.

Nancy Cicirello, PT, MPH, EdD, opened yesterday’s education program “The Continuum of Care for Individuals With Lifelong Disabilities” by identifying key issues for people with lifelong disabilities. “Eighteen percent of children under age 18 have a chronic medical condition of some type,” said Cicirello. “These individuals want to be treated with respect and not like children. The role of the PT in health and wellness programs can include...”

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Orthopaedic Section Presents Update on Use of ICF to Develop Evidence-Based Guidelines

By Don Tepper

A panel of PTs presented a progress update on the “Use of the International Classification of Functioning, Disability, and Health to Develop Evidence-Based Practice Guidelines for Common Musculoskeletal Conditions” yesterday. The speakers were John Childs, PT, PhD, OCS, CSCS, FAAOMPT, Michael Cibulka, PT, DPT, MHS, OCS, Joseph Godges, PT, DPT, MA, OCS, James Irgang, PT, PhD, ATC, and Douglas White, PT, DPT, OCS.

The International Classification of Functioning, Disability, and Health (ICF) is a unified model of functioning and disability that was recently developed by the World Health Organization (WHO). The ICF provides standard language and a framework for the description of health and health-related states in terms of body structure and function, activity, and participation in life situations. The ICF describes human function, not merely disability. It is designed to be a universal model, not a minority model. And it is an integrative model, not merely a medical one.

In 2006, the APTA's Orthopaedic Section began a project to develop evidence-based guidelines for examination and intervention of common musculoskeletal conditions based on the ICF model. Godges explained, “The practice guidelines being developed by the Orthopaedic Section will focus primarily on the structures related to movement and the neuromusculoskeletal and movement-related functions and pain categories within the ICF. These body structures and body functions will be linked with their associated health conditions from the ICD.”

Among its benefits, Godges said, the project will: Describe best practice for common musculoskeletal disorders; Classify conditions using WHO’s terminology; Identify interventions best supported by evidence; Identify appropriate outcome measures; Classify conditions using WHO’s terminology; Identify interventions best supported by evidence; Identify appropriate outcome measures; Describe best orthopedic physical therapy practice guidelines to non-PT stakeholders; Guide curriculums for professional physical therapy programs as well as orthopedic residencies and fellowships.

APTA Brand Champions

The following APTA Brand Champions are leaders in the brand-building efforts. They are here to help you understand the brand and how to “live” it. If you have questions, please e-mail any one of the leaders listed below or contact APTA’s Public Relations staff at public-relations@apta.org.

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Go to www.apta.org/brandbeat to learn more!
Don’t Miss …

❖ Join members of the Section on Pediatrics for their Member Appreciation Breakfast, 6:30 am–8:00 am in South Pacific F.
❖ Neurologic clinical specialists who are interested in practical strategies for professional growth should attend the Neurology Section Breakfast in Palm C, 7:00 am–8:30 am. The breakfast will feature the presentation, “Okay, So I’m an NCS—Now What?” Speakers will include Robin Myers, PT, NCS, and Michael Studer, PT, MHS, NCS.
❖ Enjoy a variety of coffee blends at the Starbucks Coffee Open House, 7:00 am–9:00 am in the Palm Foyer. Hosted by the Home Health Section, the event will benefit the Foundation for Physical Therapy. Tickets are $15 ($5 for students) and may be purchased at the Home Health Section’s table in the Exhibit Hall and at the door.
❖ Bella J. May, PT, EdD, FAPTA, will deliver the 2009 Cerasoli Lecture: Are We There Yet? 4:00 pm–5:00 pm in Islander F. To gain wisdom from a veteran of the profession, you must attend this event!
❖ Orthopaedic Section members: Join your peers for a Section Social Hour & Membership Meeting in South Pacific F, 5:30 pm–7:30 pm. Immediately following the meeting will be the Orthopaedic Section Awards Ceremony.
❖ The Section on Geriatrics Members Meeting and Awards Celebration will be held 5:30 pm–9:00 pm in Tradewinds D-F. Come congratulate your fellow section members!
❖ The Section on Women’s Health will hold a Business Meeting/Reception/Town Hall Meeting, 5:45 pm–8:30 pm in Islander D.
❖ Celebrate your peers’ accomplishments and mingle with friends at the Sports Physical Therapy Section Awards Reception and Ceremony. The event will take place 6:30 pm–8:00 pm in Islander E.
❖ The Acute Care Section will hold its Business Meeting and Membership Social 6:30 pm–9:30 pm in South Pacific A.
❖ End your day with cocktails and hors d’oeuvres at the Physical Therapy Political Action Committee (PT-PAC) Special Event at Eyecandy Sound Lounge in the center of Mandalay Bay’s casino floor. Tickets can be purchased for $35 at the PT-PAC booth (#435) located in the Exhibit Hall. This event is cosponsored by the Health Policy and Administration Section.
❖ Celebrate with your colleagues at the Catherine Worthingham Fellows Social Gathering on Wednesday in Coral C, 5:00 pm–6:30 pm.


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Achieving Evidence-based Practice Requires Leadership, Scheets Says

By Lois Douthitt

While the topic of her address to this year’s recipients of certification was evidence-based practice, it really was about leadership, opened Patricia Scheets, PT, DPT, NCS, on Monday night. “Only through great leadership will you be able to infuse evidence-based practices into each of your settings,” she said in her keynote address at the American Board of Physical Therapy Specialties recognition ceremony. “Only through great leadership will all of our patients enjoy the benefit of care based on the best external evidence coupled with sound clinical judgment and reasoning.”

Scheets is manager of therapy services for Carle Therapy Services in Urbana, Illinois, and has worked extensively with patients with stroke, neurological disorders, and balance and vestibular disorders.

“I believe that broad implementation of evidence-based practice in physical therapy is not an impossible dream,” Scheets said. Achieving it, though, will take “a concerted effort on the part of clinical leaders.” Clinical specialists, she said, are those leaders, possessing “the perfect combination of knowledge and understanding of external evidence coupled with clinical skills, judgment, and experience that is needed to raise a generation of evidence-based physical therapists.”

Tilting her presentation “Leading Your Village in Raising a Clinician,” Scheets explained that as leaders, clinical specialists must not only take care of their own patients but also guide the care being delivered by other physical therapists (PTs) within their communities, organizations, departments, teams, or groups—their “villages.”

Scheets discussed areas of clinical activities for which she believes leadership is needed to respond to and integrate established and emerging external evidence into daily practice. One area was how to integrate evidence in outcomes assessment into everyday practice. “There is evidence in medicine and in physical therapy that if we can do things systematically, we can improve our collective patient outcomes,” she said. “Using standardized measures is one way we can begin being more systematic in the way we deliver care and can be a starting point for evidence-based practice in your village.”

Another area Scheets addressed is managing gaps in external evidence. “At the end of the day, busy clinicians have to deliver patient care, charge for that care, and document that care,” she said. “Given that care that is delivered has to be documented, I firmly believe that the single most important thing that we can do to raise the level of our practice is to provide physical therapists with good clinical examination and evaluation forms.”

Quests for simplicity in documentation have led to simplicity in practice, Scheets claimed. She said she believes there are ways to preserve the depth and complexity of practice in efficient documentation. Even activities that seem as purely administrative as writing a job description and evaluating performance based on that description require leadership from expert practitioners. “Why would we think that having a clear bar for performance is any less important for practicing PTs—who face the pressures to cut corners, think and move more quickly, and multi-task on a daily basis?” she asked. If clinicians simplify the description of PT practice, she said—giving an extreme example of “Evaluates referred patients/Treats evaluated patients”—then they lose depth and complexity in actual practice.

“There is evidence in medicine and in physical therapy that if we can do things systematically, we can improve our collective patient outcomes.”

— Patricia Scheets

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2009 “Probably Not the Year for Health Care Reform,” Health Care Financing Speaker Predicts

By Don Tepper

“This is probably not the year for health care reform,” predicted Bill McGehee, PT, MHS, of Bradley University during the CSM 2009 session “The Financing of Health Care in America” on February 10. Instead, “We probably will see additional tweaks to the system,” he said.

He and co-speaker Patti Naylor, PT, MS, of Maryville University, addressed the public policy issues involved in the health care reform debate. Naylor first described the nature of the problem, which she identified as having two components: 1) access to service, and 2) payment for services.

Addressing cost and affordability, Naylor noted that health care expenditures as a percent of gross domestic product has risen in the United States from 7.0% in 1970 to 14.1% in 2001 and to 16.0% in 2005, putting the US far ahead of such countries as Japan (8.0% of GDP) and the United Kingdom (8.4% of GDP). Meanwhile, health care expenditures per capita have risen in the US from $384 in 1970 to $6,401 in 2005, again outpacing such countries as Japan ($2,358) and the UK ($2,724). However, using such performance benchmarks as life expectancy and infant mortality, the US rates far below those other countries.

Meanwhile, she noted, the uninsured population in the US has risen from 14.6% in 2001 to a projected 19.3% in 2010. In 2007, an estimated 45 million Americans were uninsured.

These factors, McGehee and Naylor said, present a public dilemma: the equity versus efficiency trade-off. Equity is “a fairness of distribution of services and is expressed as equal access for equal need.” On the other hand, efficiency is defined as the ratio between input and output, efforts and results, expenditure and income, or cost and resulting benefits.

The difficulty with “equity” is that fairness means different things to different people, and—at its core—raises the question of whether there is a “right” to health care. One of the difficulties with efficiency is that it requires a competitive free market: consumers must have sufficient knowledge about price, quality, and benefits of products they are purchasing.

McGehee then traced what he described as “the failed history of health care reform,” dating back to a movement in the 1910s for national health insurance, and continuing under Presidents Roosevelt, Truman, Kennedy, and their successors. He then reviewed current proposals and approaches. President Obama, for example, has called for an “affordable and high quality universal coverage through a mix of private and expanded public insurance.” Other plans have been advanced by Senator Max Baucus (D-MT) and groups such as DividedWeFail.Org and Voice ForTheUninsured.Org.

McGehee said that although he predicts another Medicare “fixer” rather than comprehensive health care reform in 2009 because of the focus on the economic stimulus plan would address health care issues. He said, “Health care is a major component of the stimulus bills. They do address some equity issues, such as full funding for IDEA. They also contain money for research, health care education, information technology, and prevention and wellness.”

Older Jocks Need Specialized Treatments, Experts Say

By Vicky Uhland

The fastest-growing population today is the aging athlete, and appropriately evaluating and treating their injuries is key, said the sports medicine professionals who gave presentations during the Tuesday afternoon session “The Aging Athlete’s Shoulder.”

Todd S. Ellenbecker, PT, DPT, MS, SCS, OCS, CSCS, clinic director, Physical Therapy Associates, Scottsdale Sports Clinic, Arizona, and director of sports medicine, ATP World Tour, cautioned that aging athletes need more than just a visual diagnosis because they may have sport-specific anatomical adaptations that can be mistaken for injuries.

For instance, Ellenbecker said, “There are some things you’ll see in a tennis player that are ‘normally abnormal’ such as ‘tennis shoulder,’” which typically shows scapular depression, downward rotation, and protraction.

Aging athletes need tests with diagnostic accuracy, he said. This is particularly important for scapular evaluation because it’s not well researched, and consequently PTs have a difficult time observing and quantifying scapular-related problems. Ellenbecker said one effective test is the Kibler Scapular Assistance Test, where the examiner raises the patient’s arm to the point of pain, and then assists the scapula as the patient again raises his arm. This helps the examiner to understand if some of the patient’s pathology is coming from the scapula, he said.

After Steven J. Nicholas, MD, Nicholas Institute of Sports Medicine and Athletic Trauma (NISMAT), and orthopedic physician for the New York Jets and New York Islanders, detailed the current surgical interventions for athletes’ arms and shoulders, his colleague Timothy F. Tyler, PT, MS, ATC, spoke about post-operative rehabilitation after rotator cuff repair.

Tyler said important factors to consider included:

- Stability
- Strength
- Function
- Range of motion
- Pain

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The Power of Independent Mobility for Infants

By Eric Ries

Citing research suggesting that “independent mobility means everything,” presenters of “Access to Independence: Why the Time is Right for Infant Power Mobility” argued Tuesday that a “power mobility gap” is preventing infants with disabilities and special needs from gaining access to power mobility devices (PMDs) and likely resulting in additional neurological and behavioral impairments, as well as creating significant social barriers for infants and their families.

Moderating the symposium was Cole Galloway, PT, PhD, director of the Infant Motor Behavior Lab at the University of Delaware, a researcher on motor behaviors of infants who quickly addressed the urgency of the issue by telling his audience that, as far as spreading the word is concerned, “What happens in Vegas can’t stay in Vegas.”

Presenting research from their 13-year collaboration on independent mobility issues in infants were David Anderson, PhD, chair of the Department of Kinesiology at San Francisco State University, and Joseph Campos, PhD, a professor in the Department of Psychology at the University of California-Berkeley. Campos described and decried “basic science’s profound bias” against the concept of self-powered mobility having any significant role in infants’ behavioral development, and he and Anderson presented video evidence from their studies that suggests that fear of heights, for example, is not innate in infants, but rather is acquired with self-powered locomotor experience.

“Locomotor experience is related to changes in visual proprioception,” Campos asserted, defining visual proprioception as “the optically produced awareness of one’s own movement and posture.” Anderson wryly asserted that he and Campos “got into the power mobility business to prove the critics wrong.”

Implications for physical therapists treating infants with permanent immobility or delayed mobility were addressed in presentations and question-and-answer periods that also included the observations and input of Amy Lynch, MS, OTR/L, a pediatric occupational therapist with a clinical interest in early intervention and assistive technology; and Sunil Agrawal, director of the University of Delaware’s Mechanical Systems Laboratory. In addition, a representative from the power-wheelchair company Permobil was on hand to help address questions about current technologies, costs, and reimbursement issues.

While the states of technology and availability are not yet such that getting infants with disabilities into power wheelchairs is practical, the presenters enumerated such transitional options for physical therapists as scooters, swings, and even Gerry-rigged PMDs. They also offered tips on purchase, rental, and reimbursement for such devices.

“Infants need to explore their world every day,” Galloway emphasized. “With decreased exploration, you’re constraining your child.”

Lesson From Uncle Sam: Patient Screening Can Encompass More Than PT Needs

By Vicky Uhland

Noting that nearly as much money is spent in the U.S. on treating patients with back pain as is spent caring for patients with cancer, Major Michael D. Ross, PT, DHS, OCS, of Travis Air Force Base, California, noted that physical therapists can help reduce those numbers by using a uniform, detailed, patient screening plan.

During the Tuesday morning session “Screening for Medical Conditions that May Present as Musculoskeletal Conditions in Physical Therapy Practice,” Ross detailed the U.S. military’s template for the appropriate screening of patients by physical therapists. (Interest in the session was so high, people had to be turned away at the door. Consequently, organizers announced that videotapes of Ross’ presentation would be available free of charge.)

“The ultimate (screening) goal is to determine if the person is in the right place—physical therapy,” Ross said, noting that “we as physical therapists are getting frustrated if our patients with low-back pain are getting better. The take-home message here is that if patients tell you they’re not getting better, that has to raise your antenna.”

Ross said a 2006 study showed physicians screened patients for “red flags” such as cancer less than 5 percent of the time, and admitted the situation isn’t much better with PTs. But with good screening, physical therapists can bridge that gap and help discover underlying health conditions, he said.

The problem is that PTs are “completely underutilized with those patient populations,” he said. “It’s very, very challenging to gather relevant information when you have a patient coming off the street who may not have their medical record. A medical screening form can capture that relevant information.”

The military’s patient screening test priorities are sensitivity and specificity, he said. If a PT is looking at tests with high sensitivity that are negative, that helps rule out the condition. Conversely, tests with high specificity help rule in the condition.

Ross said things to remember when screening a patient include:

- When you hear hoof beats, think horses, not zebras.
- Common things are common, such as nonspecific low back pain. Rare things are rare, such as cancer-causing low back pain.
- Maintain perspective on the role of medical screening in a PT practice.

Physical therapists should try to do a quick screen on all patients, including looking at their medical records, understanding what medications they’re on and trying to understand their history, Ross said. Goals in a subjective exam include understanding the patient’s problem, establishing effective communication and gaining the patient’s confidence, he said.

The ultimate (screening) goal is to determine if the person is in the right place—physical therapy,”
Forum Discusses Activities Toward Acute Care Specialty

By Lois Douthitt

Acute care physical therapists (PTs) and others interested in the process joined for a discussion of the current status and needed steps for achieving specialist certification for acute care physical therapy.

The Tuesday afternoon forum, led by a large panel, focused on answering participants’ questions and outlining three activities: garnering letters of support from PT colleagues; letters of demand (need) from PTs outside of acute care, other health care professionals, and the public; and circulating a petition of support for the specialty. The petition was available at the forum, and panelists said it would also be available at the Acute Care Section booth.

Forum panelists said they hoped to receive all support and demand letters by June so that a proposal to the American Board of Physical Therapy Specialties (ABPTS) could be submitted in August this year.

According to a document that offers guidelines for those who are approached to write support letters, the letters could be submitted by individuals or groups of PTs working in acute care practice. Information to be requested includes description of the person’s clinical practice in acute care; rationale for supporting specialist certification (the person or group’s consideration of the level autonomy needed, level of specific knowledge needed, and how specialization would influence practice); and whether or not the person or group plan(s) to pursue specialization should it become available.

On the other hand, the letters demonstrating a demand for acute care physical therapy to be recognized as a specialty area of physical therapy practice are sought from non-PT health professional leaders, planners, or administrators; PTs who are not practicing in acute care physical therapy; and the public. According to guidelines for these letters, this demand “need not be solely in relation to having specialists in acute care physical therapy practicing in the clinical setting, but can include alternate practice settings such as educational institutions, research institutions, or as consultants.”

Beyond the talk of next steps, forum participants shared ideas on a key issue of specialization—a discreet body of knowledge. Panelists and audience members said they believe there is a unique body of knowledge but it can be challenging to define or describe to those outside of acute care.

One point addressed is that acute care is not about location—a patient in a hospital, for example—but about the acuity of the patient. And as with other specialty areas, acute care physical therapy cuts across other areas and all age groups.

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Taping for Support and Immobilization

By Deb Nerud, BS, MA, NREMTP

Various conditions seen in sports and repetitive motion injuries can be managed by taping the affected area and thus stabilizing the joint involved. During yesterday’s session “Taping Techniques for Selected Upper Extremity Sports Injuries,” experts presented an overview of how physical therapists can use taping in the care of their clients.

The goal of treatment is to optimize ligament healing so as to restore function, according to Manodnya Vakil PT, OCS, SCS. However, x-rays are essential to determine if surgical intervention is required. “The ulnar collateral ligament (UCL) is a band that originates from the 1st metacarpal head and inserts into the medial aspect of the base of the proximal phalanx of the thumb. It serves as the principal stabilizer of the MCP joint ulnarily, and it is vulnerable to disruption by exposure to high energy forces as seen in certain sports,” said Vakil.

Taping is used for this condition so that the athlete may return to play, as well as to provide temporary support and immobilization. “The first consideration is to find out if the sport permits taping or splinting. You should coordinate with the coach in all cases,” said Vakil.

Vakil presented two techniques for taping skier’s thumb; one that allows the athlete to move the wrist somewhat and another in which the wrist is completely free.

Rosa Morgan PT, CHT, described various afflictions of athletes involved in ball sports and cycling, including Jersey finger, mallet finger, and boutonniere deformity, which is a disruption of the central slip of the extensor tendon over the PIP joint where the athlete is unable to extend the PIP joint. “Treatment for this condition is to splint in extension for eight weeks,” indicated Morgan.

Again a video was shown to the audience describing the taping procedure, which starts with one anchor strip at the base of the finger and then another above the joint. Two side reinforcements are added. The video instructed to position finger into extension and put a couple of “X” strips across the dorsal of the finger as well as a center strip, then use anchor strips to close this off for restriction of the PIP joint.

Paul Jonas MS, ATC, LAT, CSCS, CES, provided an overview for taping the scapula. “There is no standard system of identification for this area,” said Jonas. He suggested having a mirror in place on the wall behind the athlete so that one can see what is happening in the scapula area if you are standing in front of them. “If they still have pain after the scapula is repositioned, then there is something else to be investigated," he said.

“We use tape because it is believed that tape stimulates neuromuscular pathways by increasing the afferent feedback. You’ll want to tape in direction with muscle fibers to facilitate recruitment and tape in direction across the muscle fibers to inhibit motor unit recruitment.”

—Paul Jonas

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Continuum of Care

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routine health care screenings and promoting lifetime recreational skills.

Cicirello said that barriers to care for these individuals include access to fitness centers and equipment. “These individuals often have less routine preventive care visits,” she stated. Pointing out that disability is not synonymous with ill health, she went on to say that, “the task before us is to provide accessible consumer-friendly services, emphasize healthy living, and help problem solve.”

She introduced a former patient of hers as the next speaker. Jan Brunstrom-Hernandez, MD, is now associate professor of neurology, assistant professor of pediatrics, and director of pediatric neurology, Cerebral Palsy Center at Washington University School of Medicine at St. Louis Children’s hospital. “I don’t think I would be walking today if not for a physical therapist,” opened Brunstrom-Hernandez. “Never underestimate how important you are to your patients.”

Her message to the audience was to not “judge the capabilities on the inside by the physical problems on the outside.”

Presenter Barbara Connolly, PT, DPT, EdD, described the aging process in individuals with LLD. “Aging does not just happen when you hit 60; we are all aging,” said Connolly. “And it really starts at a younger age in those with disabilities.” Connolly said that although the life expectancy has increased for those with LLD, the average life expectancy is still less than for the general population. “The best predictor of decreased lifespan is decreased mobility,” said Connolly. “This is something we can influence as PTs.” She told attendees that LLD individuals often have increased pain, secondary musculoskeletal impairments, scoliosis, osteoarthritis, and overuse syndromes that need to be assessed by the PT.

Ellen Hamilton PT, OCS, described treating low back pain in clients with spastic diplegia. She told the audience to think about the stress these individuals put on their spine when walking. “Involuntary movements of extension, rotation, and flexion lead to compressive and shearing forces that then cause instability, disc herniation, spondylolysis, osteophytes and stenosis,” she said. “Spondylolisthesis has been considered to be one of the most obvious manifestations of lumbar instability,” said Hamilton. “Those with pain have smaller muscles at the point of pain.”

Telling the audience that cystic fibrosis (CF) is no longer a childhood disease, but a lifelong disease, Mary Massery, PT, DPT, said that CF patients are now part of a maturing population. “Within the next few years, 50 percent of all CF patients will be over 18; so half of CF patients will be adults and half will be pediatric patients. We have increased average age of death to 37 years.”

According to Massery, patients are living long enough to develop significant debilitating conditions including impaired oxygen transport, poor endurance, and decreased activity levels. “Repetitive stress causes the body to age much faster,” she said, “spine ribcage and shoulders particularly. We need to be acquainted with adult CF and the unique physical maturation and aging issues for maximizing quality of life.”

“We actually all start our journey at the same place... Each of us is born with a talent to give; some of us may just have more obstacles. You have a chance as a PT to make a huge impact during the developmental years.” —Brunstrom-Hernandez
Aging Athlete  
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consider before rehab include the type of surgical repair, intra-operative tissue quality, thickness of the tear, location of the tear, the failure mechanism that caused the tear, surrounding tissue quality, the patient’s comorbidities and goals, and the physician’s confidence in the repair.

“It’s critical to remember that all rotator cuff repairs aren’t created equal,” he said.

Keys to rehab success include protecting the repair, including avoiding gap formation. This is a new term that means anterior gapping of the repair footprint, Tyler said. Another key is restoring range of motion. At NISMAT, passive range of motion work starts between two to six weeks after surgery, depending on the type of repair. It’s also important to take things a little slower with older athletes, Tyler said.

Amee L. Seitz, PT, DPT, MS, OCS, Virginia Commonwealth University, closed the session with a discussion on the impact of aging on rotator cuff disease. RCD starts around age 40 and increases significantly each decade, she said. “But the best news is that exercise has shown to not only negate, but reverse, the effects of aging on muscle and tendons” associated with the rotator cuff, Seitz said. Clinical trials also show that ultrasound is not beneficial for RCD but manual therapy is, she said.

Product News

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