

1/16/2010

I have an interesting patient with B hip pain – the presentation is very much like B trochanteric bursitis, yet injections into the bursa gave no relief so it is probably more likely a tendon issue either of the obturators or gemelli. She presents with B O FA IR w/ TF ER. At first she had a hard time finding her R glute, but now has it. She has good frontal plane: ADLT of 5/5 B (she is a horse back rider) and ABLT of 4/5 B. I have managed to progress her to standing exercises and she can still feel her R glute with the R squat with L hip approximation, but as soon as she starts to squat any lower than this her lateral quads start to take over and she shifts her weight to the R. Do you have any suggestions for keeping her lateral quads off and her glutes and VMO's on as she squats? Does she need even more L AF IR? She has been very compliant with her HEP and can feel different muscles now when riding (R glute max and B lateral hips), yet there has been little change with her discomfort. She is in PRI orthotics as of last week and is wearing motion control shoes.

Her objective findings are:

<b>Myokin</b>	Before	Before	After	After	<b>Brachial</b>	Before	Before	After	After
	Left	Right	Left	Right		Left	Right	Left	Right
FA IR ROM	47	48			HG IR				
FA ER ROM	42	40			Shoulder Flexion				
FA IR Strength	4	5			UE Horizontal abd				
FA ER Strength	5	4			Apical expansion				
FA IR Muscle					Subclavius flexibility				
Ext Drop Test	Neg	Neg			Rib ER/elevated				
Trunk Rot	12	12							
Add Drop Test	Neg	Neg			<b>TMCC</b>				
Add lift test	5	5			Cervical Axial rot				
Abd lift test					Mandibular opening				
SLR					Mandibular lat trus				
Standing Reach	2	2			Posterior contact				

Her current HEP is:

L hemibridge

L SL R glute max w/ L adductor orange

L SL L adductor with R glute max and IO's

Prone inferior R glute max, adductor magnus and quadrates femoris stretch

R squat w/ L hip approximation

Standing resisted wall reach

Olly

1/20/2010

Thanks for your advice yesterday. Here are my findings from today (the upper grid is with orthotics and the lower one is without). She is more limited in eversion on the L in supine, yet in sidelying it looks like she is able to evert both ankles well (am I missing something). I also included a picture of her doing the Standing supported L lateral dips (this is too much for her L lateral hip causing discomfort). She has had B ankle pain in the anterior TC joint since the summer (had not mentioned this before) that came on when she fell off a horse. With the 2 grids below I was surprised at the loss of L hip ER without the orthotics when without orthotics she was able to adduct her L hip and abduct her R hip better.

O: L eversion 0 degrees inversion 35 degrees. R eversion 10 degrees inversion 25 degrees. Passive hip abd L 60 R 50.

With orthotics:

<b>Myokin</b>	Before	Before	After	After	<b>Brachial</b>	Before	Before	After	Aft
	Left	Right	Left	Right		Left	Right	Left	Rig
FA IR ROM	50	53			HG IR				
FA ER ROM	48	43			Shoulder Flexion				
FA IR Strength	4	5			UE Horizontal abd				
FA ER Strength	5	4			Apical expansion				
FA IR Muscle					Subclavius flexibility				
Ext Drop Test	Neg	Eg			Rib ER/elevated				
Trunk Rot	10.5	11							
Add Drop Test	Pos	Neg			<b>TMCC</b>				
Add lift test	4	5			Cervical Axial rot				
Abd lift test	5	5			Mandibular opening				
SLR	90	90			Mandibular lat trus				
Standing Reach	Toes	toes			Posterior contact				

<b>Myokin</b>	Before	Before	After	After	<b>Brachial</b>	Before	Before	After	Aft
	Left	Right	Left	Right		Left	Right	Left	Rig
FA IR ROM	52	50			HG IR				
FA ER ROM	39	45			Shoulder Flexion				
FA IR Strength	4	5			UE Horizontal abd				
FA ER Strength	5	4			Apical expansion				
FA IR Muscle					Subclavius flexibility				
Ext Drop Test	Neg	Neg			Rib ER/elevated				
Trunk Rot	11.5	11.5							
Add Drop Test	Neg	Neg			<b>TMCC</b>				
Add lift test	5	5			Cervical Axial rot				
Abd lift test	5 - harder	5 -			Mandibular opening				
SLR	90	90			Mandibular lat trus				
Standing Reach	3	3			Posterior contact				

Passive hip abd 60 B.

Ollly

2/3/2010

Thanks for calling yesterday. I listened to your advice and took out the L scaphoid pad and worked on frontal plane activities (she has a R scaphoid pad and B lateral heel wedges). I was amazed at how hard of a time she had with L adduction and R abduction - she clearly had me fooled with her ADLT and ABLT compensations! Her L FA ER has improved since the previous e-mail I sent and further improved with the additional frontal plane activities.

Here are her objective findings:

<b>Myokis</b>	<b>Before</b>	<b>Before</b>	<b>After</b>	<b>After</b>	<b>Orchibol</b>	<b>Before</b>	<b>Before</b>	<b>After</b>	<b>After</b>
	<b>Left</b>	<b>Right</b>	<b>Left</b>	<b>Right</b>		<b>Left</b>	<b>Right</b>	<b>Left</b>	<b>Right</b>
<b>FA IR ROM</b>	47	47	45	45	<b>HG IR</b>				
<b>FA ER ROM</b>	45	47	48	50	<b>Shoulder Flexion</b>				
<b>FA IR Strength</b>	4	5			<b>UE Horizontal abd</b>				
<b>FA ER Strength</b>	5	4			<b>Apical expansion</b>				
<b>FA IR Muscle</b>					<b>Subclavius flexibility</b>				
<b>Ext Drop Test</b>	<b>Neg</b>	<b>Neg</b>			<b>Rib ER/elevated</b>				
<b>Trunk Rot</b>	10.5	10.5							
<b>Add Drop Test</b>	<b>Neg</b>	<b>Neg</b>			<b>TMCC</b>				
<b>Add lift test</b>	5	5			<b>Cervical Axial rot</b>				
<b>Abd lift test</b>	5	5			<b>Mandibular opening</b>				
<b>SLR</b>					<b>Mandibular lat trus</b>				
<b>Standing Reach</b>	4	4			<b>Posterior contact</b>				

Her current exercises are:

- L hemibridge
- L retro step focus on finding R glute
- Supine hooking R AF ER
- L SL foot to foot w/ IO/TA's
- L SL flexed add w/ R ext abd and L ab co-activation

In the past sidelying has sometimes aggravated her hip simply from the pressure of laying on it – this was not an issue today and will hopefully not be in future either.

Will call tomorrow to see what other advice you have for exercises and how to alter her orthotics.

Take care

Olly

2/4/2010

Please thank Ron again for taking the time to talk to me this morning about my B hip pain patient. I feel I have a much better understanding of what is going on with Jen and what I need to do next. I'll have her take out the B heel wedges, try to grind the anterior portion of her R arch in her orthotic so that her hallux comes down, work on frontal plane activity and progress to squat activity with focus on inhibiting her plantarflexors by keeping her knees forward without her compensating by pronating and overstretching her flexor hallucis longus.

Thanks again

Take care

Olly

3/4/2010

I have followed Ron's instructions with my B hip pain patient – working on frontal plane and squatting with her knees in front of her toes. Found that working L thoracic abduction helped her find her L adductors and R hip abductors. Foot to foot activity is almost even B and sidelying flexed abd with extended abd and abdominals is almost even. Otherwise her objective findings are the same as last time. She likes the medial heel wedges in her orthotics. I'm having a hard time progressing her toward a squat program. Every time I try to start a L squat program her L glute max tightens and she has a harder time finding her L adductors, R hip abductors and R glute max. Also I find I am giving her a lot of exercises so as not to lose what she has gained. Her current HEP is:

- L hemibridge w/ balloon
- Supine hooking R glute max with R AF ER
- L SL foot to foot w/ IO's/TA's
- L SL flexed add w/ R ext abd and L abdominal co-activation
- Standing unsupported R AF ER - passive
- Retro stairs w/ glute max
- PRI wall squat w/ balloon
- Decline retro walk

Do you have any suggestions as to what I can leave out and how to move her from where she is to a squat program without her L glute max tightening?

3/12/2010

Hi Ollie!

To activate right AF ER and reduce left AF/FA ER, I would focus on retro stair descents with right foot on step as she lowers left, only, and retro ascents with right glute pulling left leg to same step only. I would begin reverse door squats (attached) and have her engage glutes as soon as possible in coming up from squatting with bar off door jam, as low as she can go without extending her back.

She could quit doing the Left Hemibridge with balloon and Left Sidelying Foot to Foot with IO/TA's.

Your other patient would benefit from 3 to 4 Base Down Prisms (2 to 4 hours max a day with activity) and bilateral lateral, posterior intercostals flexibility (see attached handout).

Ron