



IFOMT guidelines

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- **The vision statement of IFOMPT is:**

- *"World-wide promotion of excellence and unity in clinical and academic standards for manual/musculoskeletal physiotherapists."*

- The vision statement summarises the mission of IFOMPT that as an organisation it aims to:

- 1. Promote and maintain the high standards of specialist education and clinical practice in manual/musculoskeletal physiotherapists.

- 2. Promote and facilitate evidence based practice and research amongst its members.

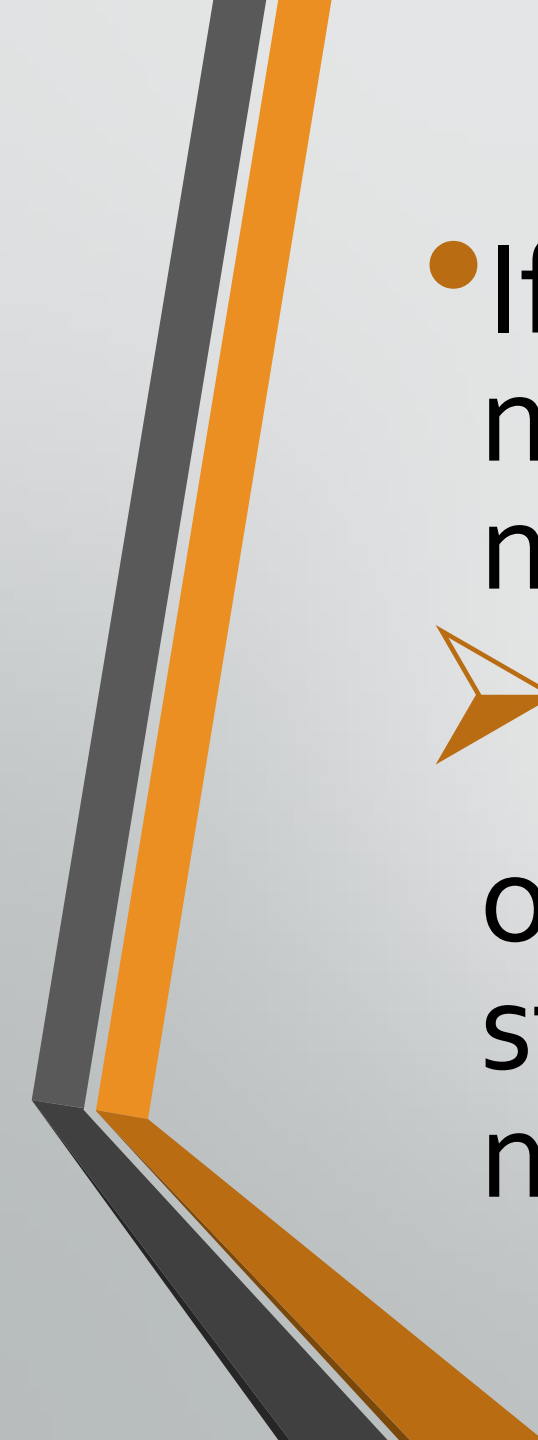
- 3. Communicate widely the purpose and level of the specialisation of manual/musculoskeletal physiotherapists amongst physiotherapists, other healthcare disciplines and the general public.

- 4. Work towards international unity/conformity of educational standards of practice amongst manual/musculoskeletal physiotherapists.

- 5. Communicate and collaborate effectively with individuals within the organisation and with other organisations.

IFOMT guidelines

- International Federation of Orthopedic Manipulative Therapists' (IFOMT) Educational Standards (1992, 1999 and 2000)
 - recognize the risks inherent in rotation manipulations, especially in the cranio-vertebral region,
- They recommend manipulative techniques which "eliminate rotary stresses and emphasize glide and distraction movements."

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- If a gentle, low-force manipulation is not successful, practitioners should not use more force,
 - but rather return to relaxation or stretch mobilizations until the joint state is amenable to a low force manipulation.

Manipulation education

- Many manipulation techniques, including most spinal manipulations, are advanced and should be used only by those with long-term training and clinical supervision.
- ❖ IFOMT guide lines recommend a specific sequence of education that begins with
 - extremity joint mobilization
 - progresses to extremity joint manipulation,before the practitioner begins to learn spinal manipulation.

If traction treatment exacerbates symptoms

It is rare for traction to increase a patient's symptoms.

➤ If it does, you should:

» **Adjust joint positioning.**

➤ Continuously monitor changes in the actual resting position and adjust the joint's three dimensional positioning as needed.

» **Alter traction force.**

➤ Early in the healing process a patient may tolerate only minimal forces .

Correct an underlying positional fault

It is a condition in which joint partners are in an abnormal position, most often involving a hypermobile joint stuck in an unusual joint position.

- minor positional faults often correct with a Grade II traction mobilization,
- strongly fixated positional faults may first need correction with a Grade III stretch glide-mobilization or manipulation.
- ❖ A positional fault can occur in both hypomobile and hypermobile joints.

Discontinue traction treatment.

In some cases, for instance

- with certain acute soft tissue lesions (e.g., ligamentous strain), traction treatment may be contraindicated along with any form of stretch to the injured fibers.
- ❖ In this case, treatment is postponed until some healing occurs.
- Stretch traction treatment may also be contraindicated in cases where symptoms are produced in an adjacent hypermobile joint which cannot be adequately locked to prevent pain during treatment.

Avoiding high-risk manual treatment

Rotation mobilization

- A void general rotation joint mobilizations.
these techniques for the spine (mobilization around the longitudinal axis)
can be effective in some cases.
- In elderly patients with lumbar facet joint arthrosis, they can also be very dangerous.
- Because general rotational mobilizations offer the promise of quick results and are relatively easy to perform, they are often misused by novice practitioners.

Rotational techniques should not be used if

there is any suspicion or history of

- disc involvement,

- vertebral artery involvement,

- irritation of nerve structures.

- ❖ In these cases, even techniques that produce a lesser vertebral rotation (e.g., muscle stretching techniques)

- can produce damaging compression forces .

The safest way

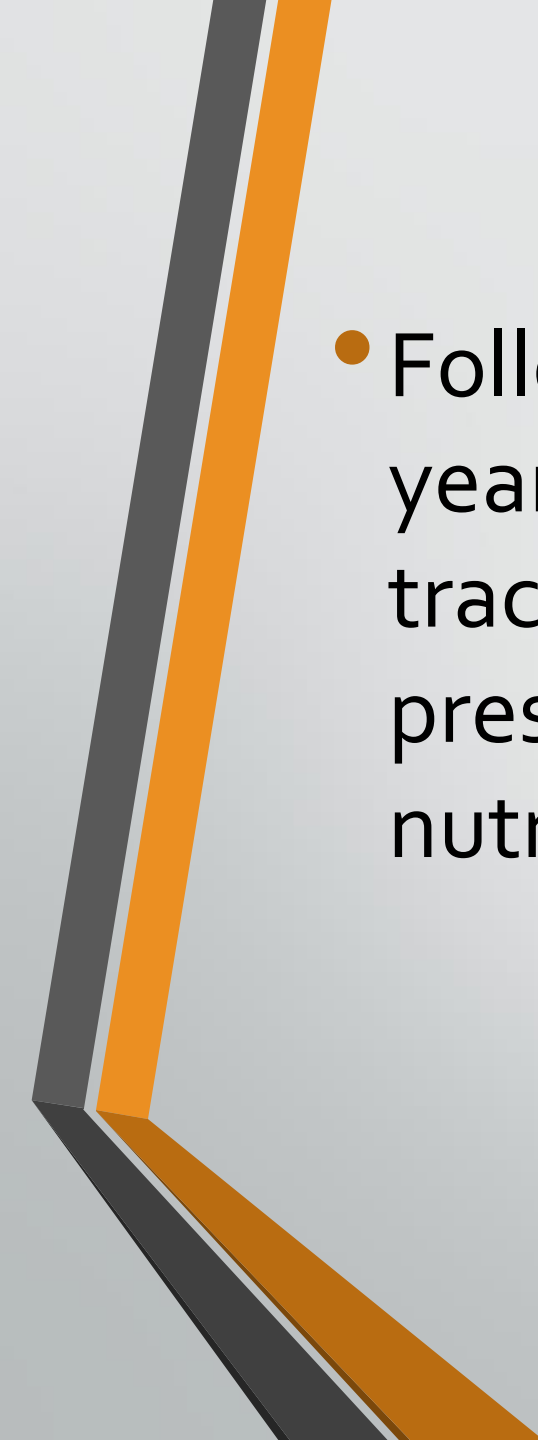
to increase spinal joint rotation range, it is safe to use


- Grade III stretch-traction mobilization in conjunction with specific three-dimensional positioning.
- Pre-position the specific spinal joint at the point of its restricted rotation, and then apply a Grade III traction mobilization at a right angle to the joint treatment plane.
- Admittedly, the skilled application of
 - three-dimensional stretch-traction mobilization is technically more difficult to apply than a general rotational mobilization,
 - ❖ but it is safer and, in skilled hands, just as effective.

Joint compression

- Avoid joint compression techniques, as they can too easily aggravate a joint condition.
- Techniques that produce indirect compression in the joint should also be used but with caution,
- particularly in cases where compression tests are symptomatic.
- ❖ While some practitioners believe that passive manual joint compression can stimulate
 - cartilage nutrition
 - regenerationso apply it for that purpose, particularly in certain extremity joints.

- Little is known about the physiological effects of manual joint compression treatment or whether an interspersed traction component is essential for its efficacy.
- Critical to the maintenance of articular cartilage is its fluid supply of nutrients by diffusion.
- This fluid nutrient transfer is facilitated by *changes in joint loading which create pressure changes.*
- ❖ *Therefore, it has been* hypothesized that compression may be a useful joint mobilization technique.

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- Following the same logic, and based on my nearly 60 years of clinical experience, I believe our intermittent traction approach may also provide the necessary pressure changes to facilitate articular cartilage nutrition.

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- Rolling, gliding, and compression are physiological stresses

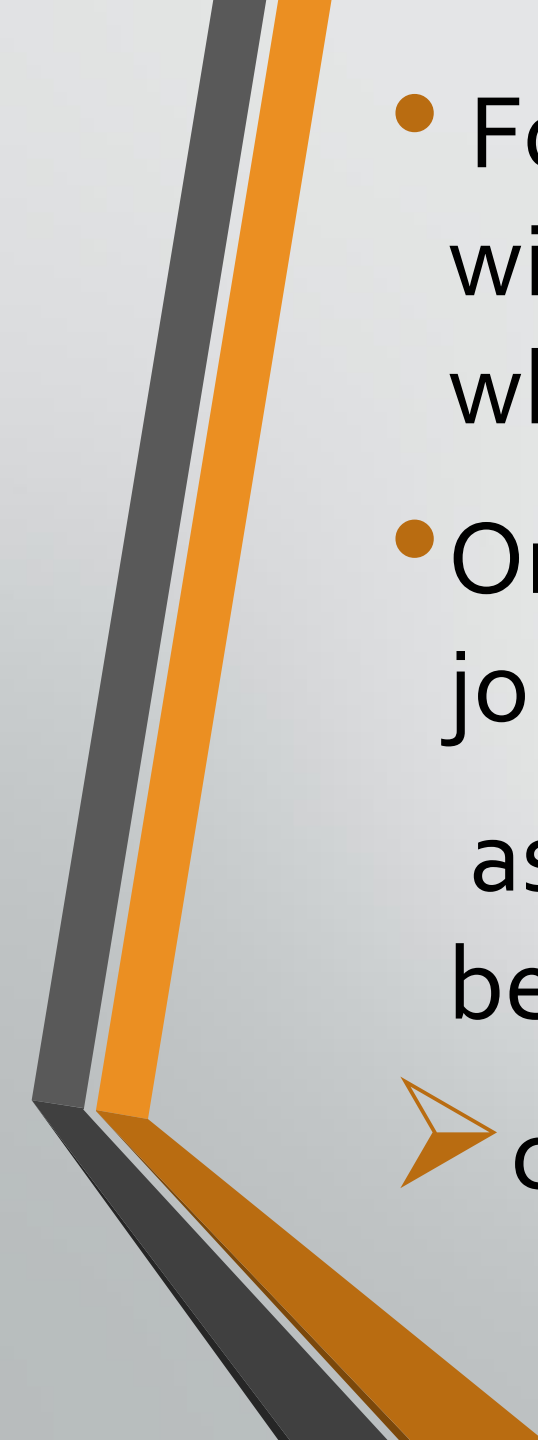
joints experience with normal movement.

- In fact, these stresses are *necessary for the maintenance of articular cartilage.*

- *When* there is an imbalance of rolling, gliding and compression,


- joints begin to show the effects of wear and tear, marking the onset of

degenerative joint disease (DJD).

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- For example, too much compression may occur with excessive running or jumping activities which can lead to DJD.
 - On the other hand, not enough stress to the joint,
 - as with prolonged immobilization in a cast or bed rest,
 - can also lead to degenerative joint disease.

Common sites of DJS

- knees
- hips
- cervical spine (Intervertebral discs & Apophyseal joints)
- lumbar spine (Intervertebral discs & Apophyseal joints)
- 1st CMC joint of hands
- 1st MTP joints in feet- Hallux Valgus

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- If joint compression occurs during a patient's treatment program, the amount of load-bearing is increased gradually and monitored closely to avoid pain.
 - ❖ Therapists **use standard protocols for graduated return to full weight-bearing** in the lower extremity joints.
 - The progression usually begins with
 - toe-touch weight bearing using two crutches
 - progresses to one crutch,
 - then a cane,
 - and eventually full weight-bearing.

- Another common progression starts with
 - active assisted movement,
 - then active movement,
 - and finally resisted movement.
- These progressions represent a kind of *graduated compression therapy* which the patient controls based on their tolerance to the activity.
- ❖ Premature load-bearing treatment can lead to joint swelling and additional injury to the patient.

- Many daily activities produce joint compression and can aggravate a patient's symptoms.
- For example,
 - side lying induces significant compression both through the shoulder girdle joint complex, in the cervical and upper thoracic spine, and in the hip joint.
- Management of this patient would likely include instruction in how to position pillows under the neck to reduce shoulder and spinal compression during side lying sleep.
- Management of this patient would also likely *avoid additional joint compression during manual treatment.*

- Be aware that our gliding techniques often also have a compression effect, especially at the end range of motion.
- If a glide-mobilization technique is painful, increase its traction component.
- If, with increased traction, the glide mobilization procedure continues to be painful, discontinue this technique.
- ❖ If joint compression tests are symptomatic, it makes little sense to use joint compression as treatment.