CMAC222

Session 1

Introduction to Chinese Medicine
Orthopedics and Traumatology

Chinese Medicine Department
Subject Rational

In this subject the clinical concepts, skills and judgements associated with Chinese Medicine traumatology and orthopaedics are presented. Western Medical perspectives of these conditions will also be highlighted in order to equip students with the necessary knowledge to interpret Western Medical investigative reports and diagnosis of these conditions.

Symptoms, signs, clinical assessments, investigations, and levels of practice evidence lead discussion around treatment prescription, prognosis and the practical acupuncture sessions where techniques are applied. By subject conclusion, a holistic understanding of traumatology and orthopaedics from a Chinese Medicine perspective has developed from students’ ability to analyse, diagnose and treat musculoskeletal disorders using acupuncture and allied techniques.
Learning Outcomes

1. Define and interpret key data necessary to make an accurate Chinese medicine diagnosis.

2. Contrast and discuss the Traditional Chinese Medicine approaches employed in the diagnosis and management of musculoskeletal disorders and sports injuries.

3. Differentiate symptom patterns and develop a Chinese medicine diagnosis, treatment principle, treatment prescription and prognosis for determined musculoskeletal disorders and conditions.

4. Apply treatment prescription using acupuncture and allied techniques.

5. Effectively demonstrate diagnostic palpation techniques and commonly used orthopaedic assessments for musculoskeletal disorders and sports injuries.

6. Adhere to occupational health and safety guidelines and infection, prevention and control guidelines for acupuncture practice as defined by CMBA.

7. Evaluate patient individual needs and modify practices showing due respect for privacy, cultural and other differences in line with CMBA Code of Conduct.
Set Text
What’s Assessable?

1. The Lecture Notes
2. The Hand outs
3. The relevant areas of the set text

"If I had an hour to solve a problem and my life depended on it, I would use the first 55 minutes determining the proper questions to ask." — Albert Einstein

Schönherz Bázis Kft, 2015
Subject Assessments

<table>
<thead>
<tr>
<th>Assessment Tasks</th>
<th>Learning Outcomes Assessed</th>
<th>Session Content Delivered</th>
<th>Session Due</th>
<th>Weighting</th>
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<tbody>
<tr>
<td>Continuous Skill Development</td>
<td>1-7</td>
<td>1-14</td>
<td>1-14</td>
<td>Pass/Fail</td>
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<tr>
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<td>1-3</td>
<td>1-6</td>
<td>Sunday</td>
<td>30%</td>
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<td>Session 6</td>
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<tr>
<td>Practical Assessment</td>
<td>1,5,6,7</td>
<td>1-14</td>
<td>Practical</td>
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<td>1-3</td>
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Continuous Skill Development

<table>
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<th>SUBJECT:</th>
<th>CMAC222 – Chinese Clinical Medicine 1</th>
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<td>Weeks 1-13</td>
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**TASK:**

In the practical component of each session of all classes, you are required to treat the conditions covered in the lecture and practice your skills. The subject will cover assessment, Chinese medicine diagnosis and treatment of common injuries and musculoskeletal pain conditions. The subject will cover acupuncture and allied treatment strategies for these common musculoskeletal conditions. The key to correct diagnosis is an accurate assessment with the correct treatment. So the focus of the subject will be on developing treatment strategies and orthopaedic assessment techniques. One of the most conditions that acupuncture treats well (backed up by research and public knowledge) is pain so getting good at treating pain is something that will help you acupuncture practice grow.

Each week you should aim to be a practitioner and a patient.

You are required to:

- Practice the 'hands on' components of each lecture in a pair or small group during the tutorial time. You will need to rotate being a practitioner and patient in each class that you attend.
- Practice each of the relevant assessment skills covered in the class.
- Practice the treatment techniques discussed in the class focussing on correct point location and manipulation methods.
- Practice each assessment method and treatment technique in a professional and safe manner with attention to patient management.
Written Assignment

Assessment Details

<table>
<thead>
<tr>
<th>Subject</th>
<th>CMAC222 – Chinese Clinical Medicine 1</th>
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<tbody>
<tr>
<td>Type</td>
<td>Written Assignment</td>
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<tr>
<td>Due Date</td>
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<td>Word Limit</td>
<td>1500-2000 words</td>
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<td>Weight</td>
<td>30%</td>
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<td>Total Marks</td>
<td>60</td>
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Your paper should be typed in Arial or Times New Roman 11-12pt font and double line spaced. Include a title page with your name, student number, class code and time, lecturer, word count.

Learning Outcomes Assessed: 1-3:

1. Define and interpret key data necessary to make an accurate Chinese medicine diagnosis.
2. Contrast and discuss the Traditional Chinese medicine approaches employed in the diagnosis and management of musculoskeletal disorders and sports injuries.
3. Differentiate symptom patterns and develop a Chinese medicine treatment prognosis and prescription for different musculoskeletal disorders and conditions.

Task: Choose a **musculoskeletal disorder** that is discussed in sessions 4-13 from the subject outline*.

Answer **ALL** of the following questions relating to your chosen condition in your written assignment:
Pre-class study slides

Starting session 4, every session has pre-class study slides within the sessions PDF document. This is on top of any required pre reading.

The pre-class study slides contain vital preparation information for the session.
Practical

Key TCM traumatology and orthopaedic methods and techniques:

1. Acupuncture
2. Moxibustion
3. Cupping
4. Gua Sha
5. Tuina
6. Electro acupuncture
7. Laser acupuncture
Classical References – Nei Jing

Huang di Nei Jing Su Wen

- Chapter 31 Discourse on Heat (shan han turns to heat)
- Chapter 39 Discourse on Pain (flow of qi)
- Chapter 41 To Pierce Lower Back Pain
- Chapter 42 Discourse on Wind
- Chapter 43 Discourse on Blocks (Bi Syndrome)
- Chapter 55 Discourse on Rules of Extended Piercing
Classical References - Ling Shu

Huang di Nei Jing Ling Shu

Chapter 1 The nine needles and the twelve origins
Chapter 13 Conduits and their sinews (what muscle is what jing jin)
Chapter 21 Cold and Heat Disease
Chapter 27 Circulation Blockage-Illness
Chapter 35 On Swelling
Chapter 39 the blood Network [Vessels]
Chapter 53 on Pain
Chapter 75 Piercing to Regulate True and Evil [Qi]
Chapter 81 Obstruction – and the Impediment Illnesses
Classical References Nan Jing

Nan Jing the Classic of Difficulties
Chapter 1 The movement in the Vessels
Chapter 2 The conduits and the Network Vessels
Chapter 6 Needling Patterns
We should begin by understanding pain

Pain

An unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage in a particular part of the body.
Characteristics of Pain

- It’s a conscious experience
- Sensory & Emotional content – It is unpleasant
- The negative aspect is an essential feature of pain
- Pain feels like damage even when there is no tissue damage
- Pain associated with actual or potential tissue damage
- Sensory information is constantly being interpreted
- Personal factors such as culture, beliefs, mood & previous experience

Legge, 2011, p94
Helpful Resources

• International Association for the Study of Pain Taxonomy – This website will help you build a glossary of terms when talking about pain so that you are consistent in the naming
  
  
• When looking at the Assignment, the Global burden of disease page on the Health Metrics and Evaluation website (IHME), helps with a bigger picture of the health condition
  
  • [www.healthdata.org/gbd](http://www.healthdata.org/gbd)
SPINAL CORD - ORIGIN FOR SPINAL NERVES

- Spinal nerves begin as roots.
- Dorsal or posterior root - incoming sensory fibers
  - dorsal root ganglion (DRG; swelling): cell bodies of sensory nerves
- Ventral or anterior root - outgoing motor fibers

sensory neurons IN
dorsal root ganglion
ventral (anterior) root(lets)
motor neurons OUT
skeletal muscles
cardiac/smooth muscle and glands
SOMATIC SENSORY PATHWAYS

Somatic sensory (somatosensory) pathways relay information from somatic receptors to the primary somatosensory area in the cerebral cortex (postcentral gyrus).

The pathways consist of three neurons:

1. **First-order neuron**: conduct impulses to the CNS (brainstem or spinal cord); either spinal or cranial nerves
2. **Second-order neuron**: conduct impulses from brain stem or spinal cord to thalamus; cross over to opposite side of body
3. **Third-order neuron**: conduct impulses from thalamus to primary somatosensory cortex
General pathway: Posterior column-medial lemniscus pathway

- Sensations conducted: proprioception, vibration, discriminative touch, weight discrimination; posture, balance and coordination of skilled movements

- Pathway: first order (signals travel up spinal cord in posterior column) → second order (fibers cross-over in medulla to become the medial lemniscus pathway ending in thalamus → third order (thalamic fibers reach cortex)
General pathway: Anterolateral (spinothalamic) pathways

- **Sensations conducted**: pain & temperature (lateral tract); tickle, itch, crude touch & pressure (anterior tract)

- **Pathway**: 
  - **First order** (first cell body in DRG with synapses in cord) → **second order** (cell body in gray matter of cord, sends fibers to other side of cord & up through white matter to synapse in thalamus); **third order** (cell body in thalamus projects to cerebral cortex)
SPINAL NERVES

- Connect CNS to sensory receptors, muscles, and glands and are part of the peripheral nervous system.

- **Structure:** mixed nerves: connected to spinal cord via posterior root (sensory axons) and anterior root (motor axons)

- **31 pairs of spinal nerves:** named and numbered according to the region and level of the spinal cord from which they emerge:
  - 8 pairs of cervical nerves
  - 12 pairs of thoracic nerves
  - 5 pairs of lumbar nerves
  - 5 pairs of sacral nerves
  - 1 pair of coccygeal nerves

- **Function:** paths of communication between the spinal cord and most of the body

  roots not in line with corresponding vertebrae so they form cauda equina
Cervical Plexus

- Ventral rami of spinal nerves: C1 to C5
- Supplies parts of head, neck & shoulders
  - Phrenic nerve (C3-C5) keeps diaphragm alive
  - Damage to cord above C3 causes respiratory arrest
Brachial plexus

- Ventral rami of spinal nerves: **C5 to T1**
- Supplies **shoulder & upper limb**
- Passes superior to first rib and under clavicle
  - Axillary n. = deltoid & teres m.
  - Musculocutaneous n. = elbow flexors
  - Radial n. = shoulder & elbow extensors
  - Median & ulnar nerves. = flexors of wrist & hand; injury results in carpal tunnel and claw hand
Lumbar plexus

- Ventral rami of spinal nerves: **L1 to L4**
- Supplies **abdominal wall, external genitals & anterior/medial thigh**

Injury to femoral nerve causes inability to extend leg & loss of sensation in thigh
Sacral plexus

- Ventral rami of spinal nerves: L4-L5 & S1-S4
- Anterior to the sacrum
- Supplies **buttocks, perineum & part of lower limb**
  - Sciatic nerve = L4 to S3 supplies post thigh & all below knee; injury results in pain that extends from the buttocok down the back of the leg; sciatic nerve injury can occur due to a herniated disc, dislocated hip, osteoarthritis, pressure from the uterus during pregnancy or an improperly administered gluteal injection.
DERMATOMES

- Skin over the entire body is segmented into dermatomes. All dermatomes are supplied by spinal nerves that carry somatic sensory nerves impulses into the spinal cord.

- All spinal nerves except C1 innervate specific dermatomes.

- Dermatomes help physician determine which segment of the spinal cord or which spinal nerve is malfunctioning.
  - NOTE: Skin on face supplied by Cranial Nerve V
Physiology of Pain

Nociceptive: Outside the nervous system

Neuropathic: Caused within the nervous system

Legge, 2011, p95
Classifications of Pain

Acute Pain
- short duration: Acute – first 48 hours
- usually has a clear cause and prognosis
- the pain can present as an acute flare up

Chronic Pain
- lasting longer than expected – not clear exactly when it becomes chronic, but generally 6 weeks+.
- Other factors are involved other than the original cause of pain.

Legge, 2011, p95
Classifications of Pain

Referred Pain

- Difficult to localise and may improve and change as the pain progresses
- Initially the pain may be vague or gnawing and felt close to the origin of symptoms (close to the midline)
- Later or if inflammation is increased, the pain may refer distally and follow a segmental or dermatomal distribution
- Can be caused by trigger points, organs or other compressed structures such as nerves and nerve roots
- Pain referred from other spinal structures such as facet joints do not tend to follow a dermatomal pattern
- Pain from a trigger point follows the pattern characteristic of the muscle not dermatomal
- Pain arising from a deep structure is perceived by the brain as coming from somewhere else

Legge, 2011, p95 & Marcus, 2004, pp 151-2
Pain from a TCM perspective
Qi & Blood Stagnation

“Tong zhi bu tong, bu tong zhi tong”

If there is free flow there is no pain, if there is pain there is no free flow.

- Pain
- Stiffness
- Tension
- Discomfort
- Numbness
- Paraesthesia

Qi leads the blood, blood nourishes Qi

E.g. Tissue damage from trauma, trigger points, degeneration

Legge, 2011, p16
Qi in the Channels

In normal channel flow, qi moves through the regular channels because they are the path of least resistance.

When there is blockage in the regular channels, flow moves into the extraordinary vessels.

Wang & Robertson, 2008, p286
Common Western Medical Diagnosis Classifications
Western Medical Diagnosis

- Fracture
- Dislocation
- Soft Tissue Injury – Sprain and Strains
- Inflammation
- Degeneration
- Paraesthesia
- Exostosis
- Rheumatoid Arthritis

How would I understand these from a TCM perspective?
Fracture

A fracture is a break in the rigid structure and continuity of a bone.

- Complete – incomplete
- Open – closed
- Simple
- Comminuted
- Compression
- Impacted
- Pathologic
- Stress
- Depressed

Symptoms: Pain, swelling, deformity, dysfunction, bony crepitus.

WikiMedia Commons, 2015
Dislocation

- Is the separation of two bones at a joint with loss of contact between the articulating bone surfaces.

- Subluxation = if the bone is only partly displaced, with partial loss of contact between the surfaces.

**Symptoms:** Pain, swelling, dysfunction, deformity, elastic fixation, flat (empty) joint.
Paraesthesia

Pins & needles
Numbness
Burning
Dermatome & Myotomes (spinal nerve)
Distal (peripheral nerve)

Common Nerve Compressions include:
- Cervical radiculopathy
- Lumbar radiculopathy
- Thoracic outlet syndrome
- Carpal Tunnel Syndrome
- Piriformis Syndrome

Exostosis

- An exostosis is an overgrowth of bone most commonly seen at a joint.
- Spurring of bone may result from excessive tension on a bone from a tendon where it attaches into the bone.
- Pain is usually the result of the spur pressing on a nerve, tendon, muscle, or getting in the way of the function of a joint.

Magee, 2014, p906
Inflammation

Injury → Chemical Mediator Release

Vasodilation of Arterioles → Local Hyperemia

Capillary Permeability → Leaky Capillaries

Local Hyperemia → RED HEAT

Leaky Capillaries → SWELLING

PAIN

Kumar et al 2013, p87
Soft Tissue Injury – Sprain and Strains
Soft Tissue Injury – Sprain and Strains

- Pain
- Swelling
- Ecchymosis

When the body experiences a sprain/strain it tries to protect the area by tightening the surrounding musculature. This is a compensation mechanism termed “splinting”.

It can change the way a person walks, affect posture or result in muscle spasm that limits movement. Continuing to participate in activities that stress the area through compensation can be a recipe for re-injury.
Strains Aetiology

- Excessive muscle effort
- Abrupt contraction
- Over stretching
- Muscle stiffness
- Impact trauma
- Muscle contusions
Aetiology:

- Inappropriate equipment, training, warm up
- Trauma / overuse
- Aggressive approach to sport
- Failure to allow minor injuries to heal
Strains Pathogenesis

- Reduced circulation
- Acute micro trauma
- Disturbed Qi and Blood flow
- Trauma resulting in pain

Marcus, 2004, p675, Legge, 2011, p270
Soft Tissue Injury – Sprain and Strains

Sprain = is a stretching or tearing of ligaments.

Strain = is a stretching or tearing of muscles or tendons.

Symptoms:
- Tenderness, swelling, discolouration, strength & range of movement limited

Legge, 2011, p109
Soft Tissue Injury – Sprain and Strains

Grading of Strains:

- **Grade 1 Tear**: a small number of fibres are torn resulting in some pain, but allowing full function.
- **Grade 2 Tear**: a significant number of fibres are torn with moderate loss of function.
- **Grade 3 Tear**: all muscle fibres are ruptured resulting in major loss of function.

The majority of calf strains are grade 2.

Marcus, 2004, p538, Legge, 2011, p110

IPC Physical Therapy, 2010
Sprain Diagnosis

- Pain – especially at the end of passive ROM
- No pain on ARROM
- Tenderness over the site of sprain
- Oedema depending on the degree of the sprain and severity of damage
- Restricted active and passive ROM
- If completely ruptured increased ROM

Legge, 2011, p122
Rheumatoid Arthritis
Rheumatoid Arthritis
Rheumatoid Arthritis (RA)

- Chronic inflammatory disease that begins in the synovial membrane
- Auto-immune disease

Aetiology
- Not established (75% rheumatic factor rf)
- Familial, infection, psychological trauma, injury, diet more common in women

Pathophysiology
- Proteins in synovial membrane attacked
- Synovial membrane becomes hyperaemic, swollen and proliferated — inflammation
- Spread to ligaments, tendons, bursa

Legge, 2011, p126-8
Rheumatoid Arthritis

Symptoms

Gradual Onset (Systemic)

- Malaise, lethargy, weight loss, generalised muscle pains
- Joint pain and stiffness (after rest)
- Swelling & deformity
- Affects small, peripheral joints first (symmetrical)
- More common in women, 25-55yrs, family history
- Shiny, very thin skin over joints, swelling & muscle wasting
- Warm moist feeling over affected joints
Trigger Points
Trigger Points

- “A highly irritable localised spot of exquisite tenderness in a nodule in a palpable taut band of skeletal muscle” - Travell & Simons (1993 & 99)

- The spots can range in size depending on what muscle fibre is implicated in the formation

- These points can be so tender that when pressed can induce a wince from the patient and called a jump sign

- Trigger points develop in the myofascia mainly in the centre of the muscle belly where the motor end plate enters. However satellite trigger points often develop due to the primary trigger point

Niel-Asher, 2008, p26
Trigger Point Animation

- Trigger Point explained with animation
- 100 Shortened sarcomeres and associated taut band

- [https://youtu.be/sltGyJvbvWw](https://youtu.be/sltGyJvbvWw)
  - Michael Akkerman 2013

Niel-Asher, 2008, p33
Trigger Point Classification

Described according to location, tenderness, and chronicity: central (or primary); satellite (or secondary); attachment; diffuse; inactive (or latent) and active.

> See handout for definitions of these!

Trigger points will have specific patterns of pain referral.

Patients describe referring pain as a deep aching quality; movement may sometimes exacerbate the symptoms, making the pain sharper.

Niel-Asher, 2008, p37
Trigger Points, Ashi Points & Motor Points

- Trigger Points can also be found in tendons, ligaments, fascia, joint capsule and even the periosteum.

- Trigger points are a logical choice to ease pain, however they may not be the best choice for long term healing – i.e. needling every ashi point – too many needles and possibly too painful for the patient

- Motor points are found in the central aspect of the muscle where the motor nerve enters the muscle, has the greatest influence on electrical activity and, as a result, the greatest impact on pain

Callison, 2012
Dermatomes
## Dermatomes

<table>
<thead>
<tr>
<th>Colours</th>
<th>Region</th>
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<tbody>
<tr>
<td>Green</td>
<td>Cervical Plexus</td>
</tr>
<tr>
<td>Blue</td>
<td>Thoracic Nerves</td>
</tr>
<tr>
<td>Purple</td>
<td>Lumbar Plexus</td>
</tr>
<tr>
<td>Red</td>
<td>Sacral Plexus</td>
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_Schematic demarcation of dermatomes (according to Keegan and Garrett) shown as distinct segments. There is actually considerable overlap between any two adjacent dermatomes. An alternative dermatome map is that provided by Foerster (see References)._  

Netter, 2004, p157
## Dermatome Levels

<table>
<thead>
<tr>
<th>Dermatome Level</th>
<th>Area Descriptions</th>
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<tbody>
<tr>
<td>C5</td>
<td>Clavicles</td>
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<tr>
<td>C5-C7</td>
<td>Lateral aspects of upper limbs</td>
</tr>
<tr>
<td>C8-T1</td>
<td>Medial aspects of upper limbs</td>
</tr>
<tr>
<td>C6</td>
<td>Thumb</td>
</tr>
<tr>
<td>C6-C8</td>
<td>Hand</td>
</tr>
<tr>
<td>C8</td>
<td>Ring and little fingers</td>
</tr>
<tr>
<td>T4</td>
<td>Level of nipples</td>
</tr>
<tr>
<td>T10</td>
<td>Level of umbilicus</td>
</tr>
<tr>
<td>T12</td>
<td>Inguinal regions</td>
</tr>
<tr>
<td>L1-4</td>
<td>Anterior and inner surfaces of lower limb</td>
</tr>
<tr>
<td>L4</td>
<td>Medial side of great toe</td>
</tr>
<tr>
<td>L5-S2</td>
<td>Posterior and outer surfaces of lower limbs</td>
</tr>
<tr>
<td>S1</td>
<td>Lateral margin of foot and little toe</td>
</tr>
<tr>
<td>S2-S4</td>
<td>Perineum</td>
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*Netter, 2004, p157*
Orthopaedic Assessment Introduction
# Basic Orthopaedic Assessment

<table>
<thead>
<tr>
<th>Assessment Strategy</th>
<th>Methods</th>
<th>Tools</th>
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<tbody>
<tr>
<td>Clinical case taking</td>
<td>Detailed health and case history</td>
<td>Clinic forms</td>
</tr>
<tr>
<td>Observation</td>
<td>Postural Assessment</td>
<td>Plumb line, grid line, subjective interpretation</td>
</tr>
<tr>
<td>Active ROM</td>
<td>Observe client-selected range of motion</td>
<td>Goniometer, inclinometer, tape measure, ruler</td>
</tr>
<tr>
<td>Passive ROM (if pain free AROM)</td>
<td>Application of overpressure; examine ‘end feel’</td>
<td>Goniometer, inclinometer, tape measure, ruler</td>
</tr>
<tr>
<td>Active resisted ROM (AAROM)</td>
<td>Application of opposing pressure to movement</td>
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</tr>
<tr>
<td>Special Tests</td>
<td>Various e.g. FPI, develop in further semesters</td>
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</table>

How to do the tests

1. Make sure the patient is comfortable.
2. Keep yourself relaxed and comfortable.
3. Interpret the findings correctly.
4. Modify the technique depending on the condition.
5. Modify the technique depending on the type of tissue.
Use the same tests regularly

1. Practice makes perfect.

2. The more exposure you get to a particular patient group or target condition, the more proficient you will become at performing the test and interpreting the results.

3. Developing the technical skills necessary to perform the tests well will improve the intra-tester reliability and increase your confidence in the findings.

4. Remember that no test is diagnostic
Contraindications

- Fracture
- Bleeding Disorders
- Tumor (not needling in it)
- Mental conditions?
- Drug or alcohol addiction
- Unconscious
- Pregnancy (Certain points at certain times)
- What else is contraindicated


WikiMedia Commons, 2015
Precautions

- Take apparent traumatic history clearly
- X-ray
- Patient past history (physical and mental history)
- Patient allergy history
- Deep needling over organs
- Vasovagal attacks
- Convulsions

## Abbreviations used

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>AS</td>
<td>Ankylosing spondylitis</td>
</tr>
<tr>
<td>CMC(j)</td>
<td>Carpometacarpal (joint)</td>
</tr>
<tr>
<td>CT</td>
<td>Computed tomography</td>
</tr>
<tr>
<td>DEXA</td>
<td>Dual energy x-ray absorptiometry</td>
</tr>
<tr>
<td>DIP(j)</td>
<td>Distal interphalangeal joint</td>
</tr>
<tr>
<td>ESR</td>
<td>Erythrocyte sedimentation rate</td>
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<tr>
<td>GALS</td>
<td>Gait, arms, legs and spine</td>
</tr>
<tr>
<td>MCP(j)</td>
<td>Metacarpophalangeal (joint)</td>
</tr>
<tr>
<td>MRI</td>
<td>Magnetic resonance imaging</td>
</tr>
<tr>
<td>MTP(J)</td>
<td>Metatarsophalangeal (joint)</td>
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<tr>
<td>NSAID</td>
<td>Non-steroidal anti-inflammatory drug</td>
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<tr>
<td>OA</td>
<td>Osteoarthritis</td>
</tr>
<tr>
<td>RA</td>
<td>Rheumatoid arthritis</td>
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</table>

Legge, 2011
Practical

Students to pair up and practice application of allied techniques. Students may choose a muscular skeletal condition if exiting conditions exist with lecturers guidance.

- Acupuncture
- Moxibustion
- Cupping
- Gua Sha
- Tuina
- Electro acupuncture
- Laser acupuncture
References

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