NORDIC OSTEOPATHIC JOURNAL

NORSK OSTEOPATFORBUND

Svenska Osteopatförbundet

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Danske Osteopater

OSTEÓPATÍA
OSTEÓPATAFÉLAG ÍSLANDS

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Redaktørens hjørne

Kjære alle lesere,

For ett år siden kunne vi stolt presentere den første utgaven av Nordic Osteopathic Journal. Med dette presenterer vi vår andre utgave. Grunnet omstendighetene har vi mistet muligheten til å møtes fysisk på fagdager og kurs. Jeg håper dette vil gi dere en god og variert lesning, med forhåpentligvis noe faglig påfyll. Takket være vår leder, samt de andre lederne i de nordiske landene, har vi fått til dette i år også. Lederne engasjerer skribenter i sine land, hvor vi i år håper vi har høynet det faglige innholdet enda mer. Vi kommer til å fortsette med denne ordningen og setter pris på tilbakemeldinger, samt bidrag til å fylle bladene med artikler og tekster. Dersom du brenner inne med noe du ønsker å formidle, oppmuntrer jeg dere alle til å ta kontakt. Sammen produserer vi innhold til dette bladet.

Ønsker dere alle en god jul og godt nyttår! Jeg håper 2021 blir fylt med mye mer møter og kurs, slik at vi kan fortsette å bygge gode kontakter og vennskap.

Mvh
Ingrid Nicander
Osteopat og redaktør
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Sjefen har ordet

Kjære medlemmer,

Gratulerer med dagen! Sent om kvelden 1. desember, mottok jeg en telefon fra en jublende glad Åshild Bruun-Gundersen, helsepolitisk talsperson for Frp. Hun kunne meddele at nå var avtalen med regjeringen som sikrer osteopater autorisasjon, i boks. Etter flere år med krevende øvelser i byråkrati, politisk navigering og alliansebygging, er vi endelig i mål. Tusen takk til alle som bidratt på veien – dette er en lagseier! Ting tar tid. Det har tatt tid å komme dit vi er i dag, og det vil ta tid før alle nødvendige brikker har falt på plass. I skrivende stund er neste etappe formelt stortingsvedtak om budsjettavtalen. Neste vil være stortingsvedtak om lovendring, hvor osteopat innlemmes i Lov om helsepersonell. Etter dette vil det ta tid med utarbeidelse av forskrifter mv, som vil gi rammene for individuell autorisasjonssøknad. NOF skal følge prosessen tett, og vi lover å holde dere orientert. Vi arbeider for alle medlemmer, uansett utdanningsvei som ført frem til kvalifikasjon som osteopat.
Vær tålmodige og følg med på de oppdateringer vi kommer til å dele underveis.
Vi osteopater er helsepersonell og skal fortsette å oppføre oss som det, både som forbund og som individer. Autorisasjon bygger på pasientsikkerhet og et prinsipp om faglig forsvarlighet. Det skal gjennomsyre alt vi gjør. Vi skal bli innlemmet i helsepersonellordningen fordi vi fortjener det.

Det nordiske samarbeidet er en styrke for oss som forbund. Det å kunne høste av erfaringer fra våre naboer og samarbeide om ulike prosjekt, er noe jeg og styret setter stor pris på.
Gjennom året har vi i Norden i felleskap fått til en serie gode webinar som erstatning for en utsatt konferanse, laget et felles fagmagasin, og hatt jevnlige dialogmøter på nett. Som mange husker la også det nordiske samarbeidet grunnlaget for at Nordisk Råd enstemmig vedtok å oppfordre Sveriges og Norges regjeringer å autorisere osteopater. Som representant for NOF har jeg som leder også blitt invitert til å sitte i Sundhedsstyrelsens rådgivende forum for autorisasjon av osteopater i Danmark. I tillegg til godt samarbeid i Norden, er vi også glade for et godt nettverk i EFFO. Her har vi deltatt aktivt med å spre gode faglige aktiviteter, og EFFO Youtube er så langt en suksess.
Året har vært krevende for mange, og det er virkelig trist å notere at noen medlemmer har måttet avvikle sin drift som konsekvens av nedstenging og ulike restriksjoner. Heldigvis gjelder dette ganske få, men det er mange som meldt om redusert omsetning for våren. Det er derfor godt å høre at for mange har sensommer og høst vært travel. Pasientene ønsker og trenger oss, noe en rekke av landets største pasientorganisasjoner sagt klart og tydelig i ulike høringssvar. Vi gjør et viktig bidrag for mange, og ønsker ikke noe annet enn å kunne fortsette å gjøre det på like vilkår som våre kolleger i førstelinjetjenesten.

Takk for tilliten og for alle tilbakemeldinger gjennom året. Fortsett med å si ifra om ting dere er opptatt av, lik, del, kommenter og hjelp oss å nå mange med vårt budskap. Vi legger nå inn neste gir, og går fremtiden optimistisk i møte.

Mvh

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Viktig!

Ved utsendelse av mail til våre medlemmer, får vi stadig mailer i retur pga feil e-mail-adresser etc. Vennligst gi beskjed til oss umiddelbart når du skifter e-mailadresse! Det er selvfølgelig også viktig å melde om ny postadresse og telefonnummer.

Pasientbrosjyrer og profilartikler:

Kan bestilles i vår webshop via medlemsweb. Her finner du det du trenger av brosjyrer, markedsmateriell, skjorter mm.

Ordrer sendes fortløpende fra vår samarbeidspartner Norgesprofil.

NORSK
OSTEOPATFORBUND

Index:

Nordic Osteopathic Alliance

Haraldur Magnússon

President of the Icelandic Osteopathic Association

Regulated since 2005, protected title and fully licensed health professional.

Number of members: 3 and a few more pending

Laura Lee Kamppila

President of the Finnish Osteopathic Association

www.osteopaattiliitto.fi
puheenjohtaja@osteopaattiliitto.fi

Regulated since 1994
Number of members: 208
Student members: 49

Tomas Collin

President of the Norwegian Osteopathic Association

www.osteopati.org

Number of members: 407
Student members: 37

Petra Nordlund

Acting President of the Swedish Osteopathic Association

ordforande@osteopatforbundet.se
www.osteopatforbundet.se

Number of members: 363
Student members: 83

Hanna Tómasdóttir

President of the Danish Osteopathic Association

hanna@danskeosteopater.dk
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Regulated since: 1. July 2018
Number of members: 217

Follow "Nordic Osteopathic Alliance" on Facebook to keep updated nordic_osteopathic_alliance

Dear colleagues,

On behalf of the five presidents of the Nordic osteopathic associations, I am proud to say that we continue to move forwards, despite the many challenges we have faced this year. This magazine is one of several products to emerge based on our cooperation and joint strive for the osteopathic community. We are in contact regularly, sometimes daily, to discuss, share and assist each other. The Nordic Osteopathic Alliance represents a useful resource, not only by arranging webinars and sharing media campaigns, but also as a platform to connect with great colleagues and friends.
The Nordic stands out as a strong and unified voice in Europe. Together we are heavily involved with EFFO, and processes regarding regulation and standards for education in the wider community. We have also contributed with a series of CPD activities presented to the EFFO membership in the format of live webinars, which have also been made available via the EFFO Youtube channel.

This year has taken its toll, but we are still standing. There are many great developments to applaud. One is the establishment of a joint MSc programme in Finland and Sweden, which you can read more about in this edition of Nordic Osteopathic Journal. You can also read up on osteopathy in sports medicine, paediatrics, and much more. Enjoy!
Finally, I am also proud to announce that on 1st December, the Norwegian government reached an agreement with the major opposition to regulate osteopathy in Norway. It has been a long and winding road to reach this goal, and there are still many challenges to face. All in all, this represents a turning point for osteopathy in Norway, and the Nordics.
Stay safe, and hope to see you at next year's Nordic Osteopathic Congress in Finland!

Kind regards,
Tomas Collin, president, NOF

Words from OIA

Text: *William J. Burke*

On behalf of the Osteopathic International Alliance (OIA) Board of Directors, I would like to bring greetings to the Nordic Osteopathic Alliance and congratulate you on the collaboration between your five Nordic Osteopathic associations in order be "strong together!". Our global osteopathic profession is stronger and more dynamic when we work together to advance and advocate for our profession, our colleagues and our patients.

For those less familiar with the OIA, we are the leading organization for the advancement and unity of the global osteopathic profession. As an "organization of organizations," the OIA unifies the profession by connecting schools, regulatory bodies, and regional, national, and multi-country groups in order to advocate for high-quality osteopathic healthcare.
Since our establishment in 2003, the OIA has maintained an active program of work with the World Health Organization (WHO), supporting WHO policies and programs, advising on matters relative to the osteopathic profession, and through attendance at annual and other meetings. As a result, the OIA was admitted into official relations with the WHO as a non-governmental organization in February 2018. This summer, we agreed to renew our partnership for another three-year term (2021-23). This allows us to complete our ongoing collaborative projects:
1. An updated Survey of the Global Osteopathic Profession, 2. The development of an Osteopathic Glossary, and 3. An updated Benchmarks in Training for Osteopathy.

This is a difficult time for all of us as human beings and as healthcare providers. The COVID-19 pandemic has led to personal and professional challenges as we struggle to maintain our own health and that of our families, as well as the health of our patients. It is my hope that you are finding time to focus on your own well-being. In addition to exercising, eating a healthy diet and finding time to rest and relax, I find interactions with my colleagues to be a source of energy and rejuvenation. Perhaps you will consider joining us for learning and restoration at the OIA's next conference in May of 2021 taking place at the beautiful Copacabana Hotel in Rio de Janeiro, Brazil!

William J. Burke
D.O

The benefits of authorisation of osteopaths

Text: *Hanna Tómasdóttir*

Osteopathy has been an 'authorised' healthcare profession in Denmark since 1 July 2018. The authorisation of osteopathy means that an official licence is required to practice as an osteopath in Denmark, and the title 'osteopat' is protected by law.

Today, almost 2½ years later, the Danish Patient Safety Authority has issued 140 official licences to practice as an osteopath in Denmark, which means that about 75% of Danske Osteopater's membership have now received their authorisation to practice.

What are the real benefits of authorisation? There are many. One of them is establishing an appropriate level of professional education to secure the quality of clinical practice, and even more importantly, to assure patient safety.

The Nordic region will become the most sustainable and integrated region in the world in 2030.

All persons who apply for an official authorisation to practice as an osteopath in Denmark must have completed healthcare training in osteopathy, corresponding to the level of a professional bachelor's degree, according to the Danish 'Executive Order on the Authorisation of Osteopaths'. Defining a level for education is an important step, as too many institutions, globally, offer osteopathic training which does not comply with the two international standards for osteopathy: the WHO Benchmark for Training in Osteopathy, published in 2010, and the European Standard, Comité Européen de Normalisation (CEN), on Osteopathic Healthcare Provision, published in 2015. These standards define the benchmark for high quality clinical practice, education, safety and ethics for osteopathy.

Authorisation also means that osteopaths in Denmark are now recognised as part of the primary healthcare sector, and are therefore involved in all communications and regular meetings with the Ministry of Health, and the whole primary healthcare sector, which has been very valuable in dealing with the current COVID-19 pandemic situation. Danske Osteopater have also been represented in the national reference and working groups, alongside with other authorised healthcare professionals, developing new National Clinical Guidelines for examination and treatment of breastfeeding children with posterior tongue-tie (ankyloglossia), and non-medical treatment of headache (migraine and tension-type headaches).

We need an official authorisation of our profession in both Norway and Sweden, both with respect to the described benefits for patients and the profession, but also to improve and facilitate free mobility to practice as an osteopath in all the Nordic countries. As stated in the aim of the Nordic co-operation between Denmark, Finland, Iceland, Norway, Sweden, the Faroe Islands, Greenland and Åland:
"The Nordic region will become the most sustainable and integrated region in the world in 2030. The co-operation in the Nordic Council of Ministers must serve this purpose."

Want to read more about the demands and premises to obtain an authorisation as an osteopath in Denmark?

Here is a link to information in both Danish and English:
https://www.danskeosteopater.dk/autorisation/

Hanna Tómasdóttir
President of the Danish Osteopathic Association
President of the European Federation & Forum for Osteopathy

Neuromusculoskeletal pain syndromes associated with hyper-and hypothyroidism – a bachelor thesis

Text: *Charlotte Nelin*

Introduction

The Swedish Thyroid Association (Sköldkörtelförbundet) published a bachelor thesis which investigated the association between neuromusculoskeletal pain syndromes and hyper-and hypothyroidism (hyper-and hyposecretion of thyroid hormones).
The results of the thesis showed that the only manifestations of a thyroid disorder could be neurological, muscular or skeletal symptoms. The majority of patients with hyper-or hypothyroidism have neuromuscular complaints, and many experienced clinical weakness and neuropathies. A large group of these patients also suffer from residual symptoms related to neuromusculoskeletal issues.

Background & purpose

According to statistics from the National Board of Welfare (Socialstyrelsen) in 2018, approximately 4,5% of the Swedish population were diagnosed with and treated for thyroid disorders, whereof 82% were female. The yearly increase of new patients with hypothyroidism, i.e. without prior thyroid treatment, was 8%. Considering that up to 30% of patients were reporting residual symptoms, even though on medication and with what is regarded to be normal thyroid hormone levels (biochemical normalization or euthyroidism), the diagnosis and treatment guidelines are being questioned and discussed.

The purpose of the bachelor thesis was to investigate which neuromusculoskeletal pain syndromes could be associated with hyper-and hypothyroidism, both before diagnosis of the thyroid disorder and during treatment. The thesis focused on the neuromusculoskeletal complaints and diagnoses in patients before or in connection with their thyroid disorder diagnosis, or as a residual symptom during their treatment.

The results

The result of the study was summarized in two overviews, where both those pain syndromes which could be indicating hyper-or hypothyroidism as well as those associated with a confirmed diagnosis were included. The most commonly associated diagnoses for both hyper-and hypothyroidism were carpal tunnel syndrome, adhesive capsulitis (frozen shoulder) and Dupuytren's contracture (flexion contracture in the hand, usually affecting the little & ring fingers).
For patients with hyperthyroidism a vast majority reported neuromuscular symptoms, most of which was confirmed to be clinical weakness and neuropathies. Myopathy, muscle weakness, stiffness and atrophy were very common. 76% suffered from tremor and 38% had hyperreflexia. The soft tissue diagnoses tended to be located in the upper extremities and the skeletal issues related to osteopenia and osteoporosis had a very wide prevalence range (3,5-50%). Figure 1 is the overview for patients with hyperthyroidism.

For patients with hypothyroidism, the neuromuscular complaints were even more common than in patients with hyperthyroidism, the confirmed weakness was less, and the neuropathies were twice as prevalent. The diagnoses of hypothyroid myopathy and hypothyroid arthropathy were described and linked to clinical representation. The prevalence of soft tissue diagnoses was higher, sometimes 2-3 times higher, than in patients with hyperthyroidism. The joint and skeletal issues besides hypothyroid arthropathy, were more varied than in patients with hyperthyroidism, with irregular epiphyses, aseptic necrosis and erosive osteoarthritis. Figure 2 is the overview for patients with hypothyroidism.

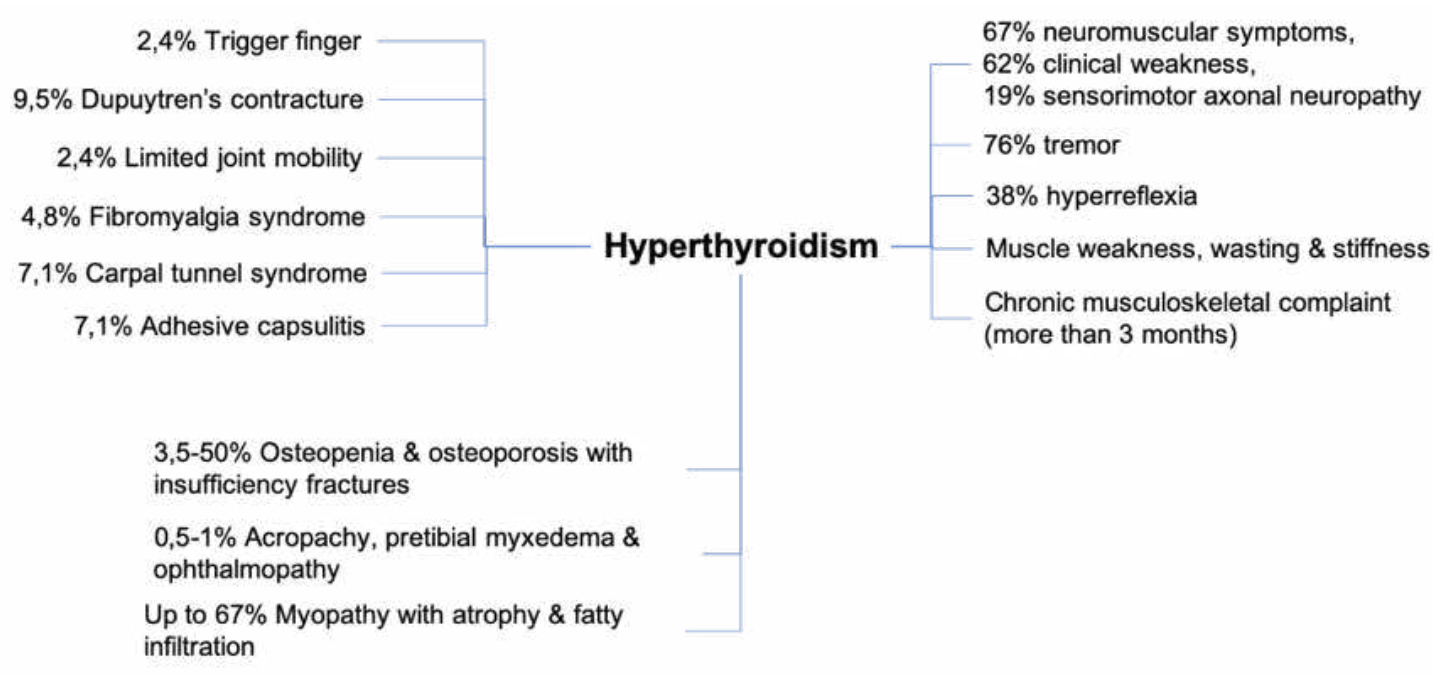

Figure 1. Overview of neuromusculoskeletal pain syndromes associated with hyperthyroidism

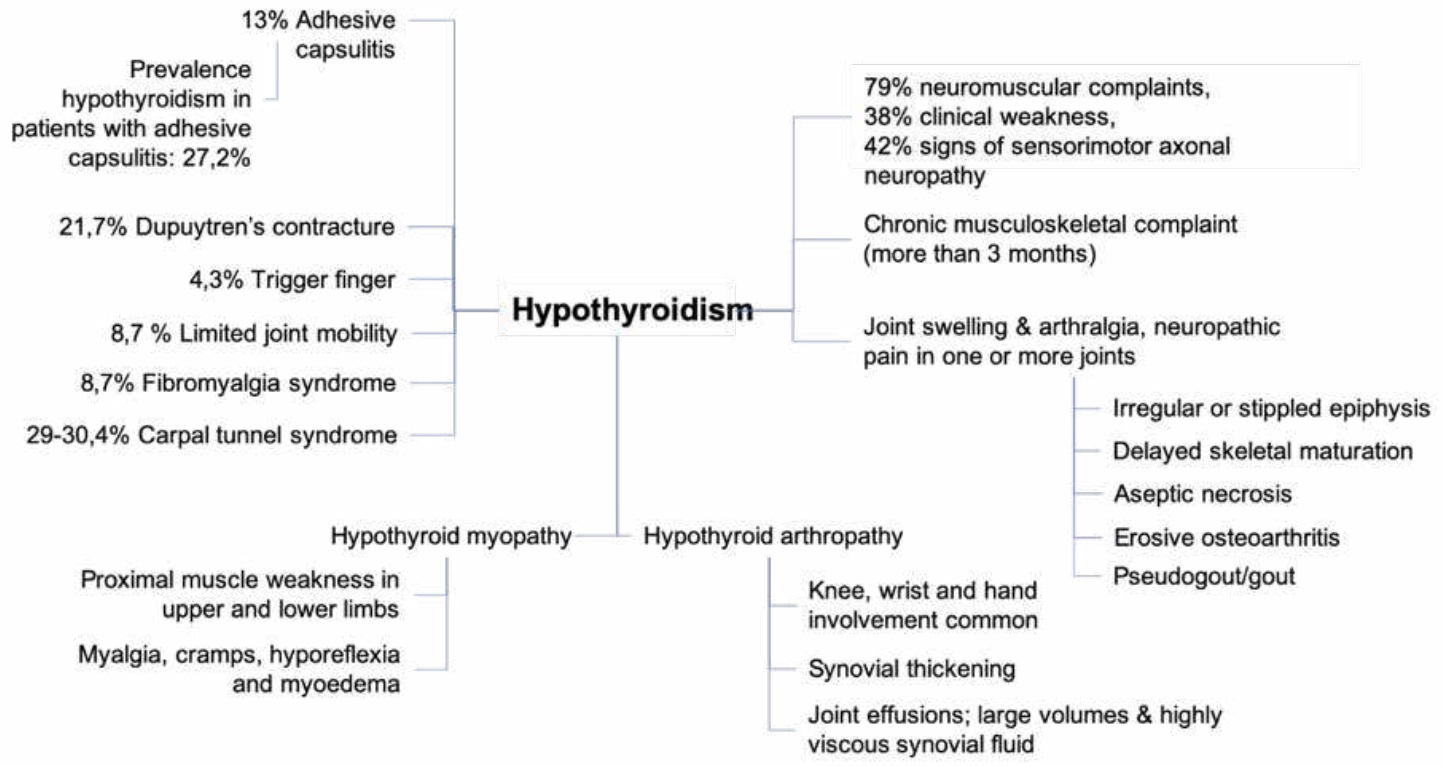

Figure 2. Overview of the neuromusculoskeletal pain syndromes associated with hypothyroidism

Why is this important for osteopaths and manual therapy?

The identification and recognition of neuromusculoskeletal signs and symptoms which could be either the initial manifestation of a thyroid disorder or an associated issue is of importance for all potential health care contacts, including osteopaths, to provide fast and correct treatment.

A skeletal, muscular or neurological symptom could be the only manifestation of a thyroid disorder, and if caught early and investigated, recovery was usually quick and more complete. If the patient already was diagnosed, under treatment, confirmed to be biochemically compensated and stable, it was however also of clinical relevance to note and act on any residual skeletal, muscular or neurological issues that might be related to the patient's thyroid disorder.

By integrating the knowledge of these associations into clinical practice and decision-making, it could provide an opportunity to quicker make the correct diagnosis and ultimately provide better total care. Research included in the thesis showed that for 36% of patients with hyperthyroidism, and 16% with hypothyroidism musculoskeletal complaints where their reason for the visit to the doctor. These figures could be an indication that the patient would instead contact an osteopath, with the same complaint, so increased awareness and knowledge about the coexistence of various neuromusculoskeletal disorders with thyroid dysfunction is essential.

Final comment

In the process of writing my thesis, I was in regular contact with the Swedish Thyroid Association (Sköldkörtelförbundet) and also used information from their website to get more details about the patient community in Sweden, current discussions and background. I am grateful for their support and cooperation in the process as well as their decision to publish the thesis.

Link

https://skoldkortelforbundet.se/which-neuromusculoskeletal-pain-syndromes-are-associated-with-hyper-and-hypothyroidism-kandidatuppsats-i-osteopati/

Scan the QR-code to read the article.

Charlotte Nelin
Osteopathic student at Skandinaviska Osteopathögskolan, Göteborg, Sweden

Case Study: Response of Infant Gastroesophageal Reflux (GER)

Text: *Didde Thorsted*

Written and signed patient consent form was obtained

Key words: gastroesophageal reflux, GER, Paediatric, Osteopathic treatment, Infant,

Abstract

Introduction: This case report will discuss the role of pediatric osteopathic treatment in solving gastroesophageal reflux (GER) in an infant.

Case Presentation: The mother of an 6 weeks old infant presented her infant for osteopathic treatment with a diagnosis of GER. The mothers complaint also included fussiness, excessive crying, constant hyperextension, interrupted sleep,and troublesome breastfeeding. After the first treatment the mother reported, by mail, improvements in sleep and crying. Because of a positive test for lip and tongue tie the infant was referred back to the MD. The response was a referral to physiotherapy. After a series of unsuccessful treatments the infant was again
presented for osteopathic treatment at age 12 weeks with the same primary and secondary complaints now accompanied by weight loss and motor skill development concerns.

Management and Outcome: A course of 6 osteopathic treatments and revision of the tethered oral tissue in Holland was applied over a period of 2,5 months around revision. Consisting of spinal adjustments adapted for infant use, cranial osteopathic techniques, facial and muscular release techniques, visceral mobilization and mobilizing exercises for home use. Using I-GER-Q (table A) and Thrive schedule (table B) to asses progress notable improvements were attained throughout the treatment period with full recovery of primary and secondary complaints.

Discussion: This case showed an improvement on GER after osteopathic treatment. The I-GER-Q is accessed to be an efficient tool when assessing GER and differentiating between GER and GERD 1,2). When using I-GER-Q as assessment tool the infant suffered from GERD but the medical diagnosis was GER. This stresses a need for diagnosis consensus between therapists to provide the optimal treatment. The thrive schedule has not been validated. Osteopathic treatment is tailor made to each individual and therefore a golden standard for treating this diagnosis is impossible to set.

Introduction:

Infants suffering from GER and GERD is one of the most common reasons for parents seeking treatment. Many parents are still meet with the statement that infant GER is a "fashion diagnosis" and not a real problem despite the ongoing research trying to uncover the cause and optimize the diagnosis tools 3). The majority of infants that receive the diagnosis in Denmark are still diagnosed on the base symptoms reported by the parents and experimental use of PPI. Today the primary treatment is still Nexium
or Lansoprazol despite studies proving them ineffective and a cause of serious side effects 4,5,6) No dietary advise is offered despite studies showing a high correlation between GER symptoms and cows milk intolerance 7,8,9) and even tethered oral tissue could play a role in GER and should be ruled out before medicating an infant 10,11,12,13,14). A few studies show good effect on GER using manual treatment 15,16) and more effort should be put into proving the effect of osteopathic treatment as a non invasive efficient and safe 17) treatment for GER and GERD.

Case Presentation:
A 6 weeks old infant presented for pediatric osteopathic treatment for the diagnosis of
GER. Secondary complaint included fussiness, excessive crying, constant hyperextension, interrupted sleep, and troublesome breastfeeding.
The pregnancy was good both physical, emotional and mentally.
The mother followed a vegetarian diet with some fish, supplemented with probiotics and Omega 3. She was physically active doing yoga and walking throughout the pregnancy. The delivery was a home birth with natural onset, with acupuncture assistance, week 41+6 and no medical intervention. The Infant was born after 9 hours labour after a 45 minutes pushing period. Apgar score of 10/10.
The breastfeeding was troublesome from the start with sores, lipstick shaped nibbles and severe pain when feeding. The feedings were short and often with the infant dozing of while eating or getting angry and arcing away, screaming, fussing at the breast, pushing and pulling. The breastfeeding consultant expressed concern and supervised in alternative feeding positions.
The infant was in general fussy, crying excessively and had to be carried in an elastic wrap to sleep. Even in the wrap the sleep was short and interrupted. The infant was in constant hyperextension and preferred an upright position. It also presented with excessive hiccups, irritated mucosa in the nose, regurgitations, periods with red eyes, coughing, wheezing and snoring sounds.

The Infant had fallen one percentile from birthweight, breathing, tone, reflexes were all normal but leaned towards a more sympathetic state, with wet and cold hands and feet. The contact was short but intense.

A general hyperextension was noted from the pelvis to the skull with elevated membranous tension. An anteriorisation of the pelvis and a compression on the sacrum was evident. Elevation of the lower ribs affected the diaphragmatic ROM and the ability to stabilize the trunk. Tension in the deep front line, central fascial chain and cervical fascial system. Increased muscle tone in supra and infrahyoid mm, masticatory mm and sub occipital mm. Hyoid was retracted and placed superior. High tension was found in the TMJ, with retraction of the mandible and a high palate. Anteriorisation of the head was noted and condylar compression. Tension was found in ligamentum terres, omentum minor and around cardia.
Evident limitation of tongue movement and upper lip flexibility.

Assessing GER on the I-GER-Q the infant obtained a score of 17 (Table A). Assessing

Legends:
Table A Schedule translated to danish from GER vs. GERD in INFANTS. MODIFIED ORENSTEIN'S INFANT GER QUESTIONAIRE

	Question	*Points*
1.	How often does the baby usually spit up?	
	• 1 to 3 times per day	1
	• 3 to 5 times per day	2
	• >5 times/day	3
2.	How much does the baby usually spit up?	
	• 1 teaspoonful to 1 tablespoonful	1
	• 1 tablespoonful to 1 ounce	2
	• >1 ounce	3
3.	Does the spitting up seem to be uncomfortable for the baby?	2
4.	Does the baby refuse feeding even when hungry?	1
5.	Does the baby have trouble gaining enough weight?	1
6.	Does the baby cry a lot during or after feeding?	3
7.	Do you think the baby cries or fusses more than normal?	1
8.	How many hours does the baby cry or fuss each day?	
	• 1 to 3 hours	1
	• >3 hours	2
9.	Do you think the baby hiccups more than most babies?	1
10.	Does the baby have spells of arching back?	2
11.	Has the baby ever stopped breathing while awake and struggling to breathe or turn blue or purple?	6
	Maximum total score	**25**

• *Score >7, sensitivity: 74% and specificity: 94% for diagnosing GERD*

Kl.	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	1	2	3	4	5	6	7
Dag 1																								
Kl.	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	1	2	3	4	5	6	7
Dag 2																								
Kl.	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	1	2	3	4	5	6	7
Dag 3																								
Kl.	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	1	2	3	4	5	6	7
Dag 4																								
Kl.	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	1	2	3	4	5	6	7
Dag 5																								
Kl.	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	1	2	3	4	5	6	7
Dag 6																								
Kl.	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	1	2	3	4	5	6	7
Dag 7																								

Søvn Gråd kan trøstes Gråd utrøstelig Spiser = **S** Afføring = **A** Tis = **T** Reflux = **R**

Table B Schedule translated and modified from Anja Caers www.happybabycoach.com

the tethered oral tissue the infant scored 3 on BTAT (Table C) and with HALFF (Table D) appearance 6 and function 6 leading to a diagnosis of Ankyloglossia. The frenulum of the lip showed an immobile class 3 ULT. The mother was asked to use the Thrive schedule (Table B) to assess the infants progress and were referred back to the MD because of the structure restraints that could be a course of Aerophagia Induced Reflux (AIR). The mother reported an improvement in sleep and crying by mail. MD referred to physiotherapy.

At the age of 12 weeks the infant was presented for osteopathic treatment a second time. Primary and secondary complaints was unchanged and now accompanied by weight loss and motor skill development concerns.

When accessing the infants motor skill development in supine it presented with a full 8 weeks normal development with no attempt to do leg lift without stimulation on lower ribs. When testing in prone position the infant presents with a development equalling 6-8 weeks with a cervical hyperextension, lack of scapula stabilization and paraspinal action. An SLR into extension was still evident and not yet fully converted, when testing the primary reflexes.

Management and Outcome:

The course consisted of 6 osteopathic treatments, the first at 6 weeks the second at 12 weeks. A revision of the tethered oral tissue was advised. The infant was revised in Holland at 15 weeks. The infant was treated 4 times over a period of 7 weeks after revision. First treatment 1 week after revision, second treatment 2 weeks after, third treatment 4 weeks after and fourth treatment 7 weeks after. Measurements were taken at the 1st, 2nd and 6th treatment.

The choice of techniques used was based on current findings at the time of the appointment therefore not all techniques were applied at every treatment. The techniques consisted of : *Manipulative release techniques* for the SI joints, mid and high thoracic spine and ribs Mobilization of the sacrum, Ilium, cervical spine, thoracolumbar junction, lower ribs, diaphragm, mid and high thoracic spine, TMJ, hyoid, muscles of mastication, supra and infrahyoid muscles. Soft tissue release and stretch of diaphragm, cervical muscles , suboccipital muscles, mastication muscles, submandibular muscles, the cervical fascias and central fascial system and release of the scartcissue from revision.
Massage of cervical, suboccipital, supra and infra hyoid muscles and paraspinal muscles. Cranial techniques including Infant CBR , condylar decompression with oral fixation, lift procedure, five star membranous release. Release of the palate. Visceral techniques for ligamentum terres, omentum minor and cardia.

The treatment was accompanied by aftercare for the tethered oral tissue, home exercise and massage to decrease extension and strengthen flexors. Additional advice was provided concerning holding, handling and feeding positions. The parents were also instructed in optimal sleep position. The crying and sleep were measured by the parents on a schedule (table B)

After the first treatment before revision the mother reported improvements in sleep and crying with unchanged GER. Assessment on I-GER-Q and BTAT and HALFF was unchanged.

After the second treatment before revision the mother again reported improvements in sleep, crying and more mobility in the TMJ, a slight improvement on the hyperextension and abdominal strength but with unchanged GER.

First treatment after revision the mother reported a 60% improvement in GER, less fussiness at the breast, a more strong and flexible infant. Still better sleep, no crying, spontaneous leg lift and more stable in prone position. The infant could now be placed on a blanket to play. Mother was given DNS exercises for the motor skill development.

Second treatment after revision the mother reported a 75% improvement in GER, after last treatment the infant was no longer fussy when eating and started rolling from supine to prone. Sleep and crying was normal. Mother was given DNS exercises for the prone position working to stabilize the scapula and increase paraspinal activity and decrease cervical extension. The scar had to be manually reopened because of early closure despite aftercare exercises. Weight gain was noted by the health nurse.

Third treatment after revision primary and secondary complaints was resolved.
A need for motor skill stimulation was still needed and slight tension was still evident in and around the mouth, central fascial system and diaphragm. An ongoing weight gain was noted.

Fourth treatment the assessment of the GER on the I-GER-Q the infant obtained a score of 0 (Table A). Assessing the tethered oral tissue the infant scored 7 on BTAT (Table C) and with HALFF (Table D) appearance 9 and function12 leading to a diagnosis of no ankyloglossia. The infants weight was now stable. The mother was instructed in home exercises and stretches.

Discussion

In this case a good effect was noted on the infants primary and secondary complaints with osteopathic treatment. The fact that osteopathy is more a treatment philosophy than a few specific manual techniques and that a revision of the tethered oral tissue was needed makes it hard to conclude what part of the treatment provided the results.
A part of the osteopathic philosophy is that all treatments are tailor made to fit the unique individual and we treat the specific findings instead of following a specific regime. Therefore a golden standard is hard to set. This infant had many secondary complaints linked to the musculoskeletal restrictions witch also clutter the picture.

This case demonstrates that a multiple angel approach combining osteopathic treatment with revision, home exercise and advice had the desired effect on the infants complaints. This study suggests to the possibility that similar patients may benefit from osteopathic treatment when suffering from GER and GERD.

Bristol Tongue Assessment Tool (BTAT)			
Elements	**0**	**1**	**2**
Tongue tip appearance	Heart shaped	Slight cleft / notched	Rounded
Attachment of frenulum to lower gum ridge	Attached at top of gum ridge	Attached to inner aspect of gum	Attached to floor of mouth
Lift of tongue with mouth wide (crying)	Minimal tongue lift	Edges only to mid-mouth	Full tongue lift to mid-mouth
Protrusion of tongue	Tip stays behind gum	Tip over gum	Tip can ascend over lower lip

Table C: The Bristol Tongue Assessment Tool (BTAT)
Scores of 0-3 indicate more severe reduction of tongue function.

Table D: Hazelbaker Assessment tool

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Hazelbaker Assessment for Lingual Frenulum Function*

Appearance Items	Function Items
Appearance of tongue when lifted 2: Round or square 1: Slight cleft in tip apparent 0: Heart- or V-shaped ***Elasticity of frenulum*** 2: Very elastic 1: Moderately elastic 0: Little or no elasticity ***Length of lingual frenulum when tongue lifted*** 2: > 1 cm 1: 1 cm 0: <1 cm ***Attachment of lingual frenulum to tongue*** 2: Posterior to tip 1: At tip 0: Notched tip ***Attachment of lingual frenulum to inferior alveolar ridge*** 2: Attached to floor of mouth or well below ridge 1: Attached just below ridge 0: Attached at ridge -Significant ankyloglossia is diagnosed when the appearance score total is 8 or less and/or function score total was 11 or less. -Severe maternal nipple pain during breastfeeding, without alternate explanation as assessed by a Lactation Consultant, is also grounds to consider frenotomy if a tight anterior frenulum is noted. **Ankyloglossia Grading:** Class I: mild ankyloglossia, 12-16 mm Class II: moderate ankyloglossia, 8-11mm Class III: severe ankyloglossia, 3-7 mm Class IV: complete ankyloglossia, less than 3 mm 9	***Lateralization*** 2: Complete 1: Body of tongue but not tongue tip 0: None ***Lift of tongue*** 2: Tip to mid-mouth 1: Only edges to mid-mouth 0: Tip stays at lower alveolar ridge or rises to mid-mouth only with jaw closure ***Extension of tongue*** 2: Tip over lower lip 1: Tip over lower gum only 0: Neither of the above, or anterior or mid-tongue humps ***Spread of anterior tongue*** 2: Complete 1: Moderate or partial 0: Little or none ***Cupping*** 2: Entire edge, firm cup 1: Side edges only, moderate cup 0: Poor or no cup ***Peristalsis*** 2: Complete, anterior to posterior 1: Partial, originating posterior to tip 0: None or reverse motion ***Snapback*** 2: None 1: Periodic 0: Frequent or with each suck **SCORE:** Appearance:_____(<8 = ankyloglossia) Function:_____(<11 = ankyloglossia)

*Adapted with permission from Hazelbaker.

Appearance of the tongue when lifted is determined by inspecting the anterior edge of the tongue as the infant cries or tries to lift or extend the tongue.
The elasticity of the frenulum is determined by palpating the frenulum for elasticity while lifting the infant's tongue.
The length of the lingual frenulum is determined by noting its approximate length in centimeters as the tongue is lifted.
Attachment of the frenulum to the tongue is determined by noting its origin on the inferior aspect of the tongue. It should be approximately 1 cm posterior to the tip.
The attachment of the lingual frenulum to the inferior alveolar ridge is determined by noting the location of the anterior attachment of the frenulum. It should insert proximal to or into the genioglossus muscle on the floor of the mouth.
Lateralization is measured by eliciting the transverse tongue reflex by tracing the lower gum ridge and brushing the lateral edge of the tongue with the examiner's finger.
Lift of the tongue is noted when the finger is removed from the infant's mouth. If the infant cries, then the tongue tip should lift to mid-mouth without jaw closure.
Extension of the tongue is measured by eliciting the tongue extrusion reflex by brushing the lower lip downward toward the chin.
Spread of anterior tongue is determined by first eliciting a rooting reflex, just before cupping, by tickling the upper and lower lips and looking for even thinning of the anterior tongue.
Cupping is a measure of the degree to which the tongue hugs the finger as the infant sucks on it.
Peristalsis is a backward, wave-like motion of the tongue during sucking that should originate at the tip of the tongue and is felt with the back of the examiner's finger.
Snapback is heard as a clucking sound when the tethered tongue loses it grasp on the finger or breast when the infant tries to generate negative pressure.

Ballard, J.L., Auer, C.E., Khoury, J.C. (2002). Ankyloglossia: Assessment, Incidence, and Effect of Frenuloplasty on the Breastfeeding Dyad. *Pediatrics* 2002;110;e63

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References:

1) Orenstein SR, Shalaby TM, Cohn JF. Reflux symptoms in 100 normal infants: diagnostic validity of the infant gastroesophageal reflux questionnaire. Clin Pediatr. 1996;35:607-14.
2) Orenstein SR. Symptoms and Reflux in Infants: Infant Gastroesophageal Reflux Questionnaire Revised (I-GERQ-R)–Utility for Symptom Tracking and Diagnosis Current Gastroenterology Reports. December 2010, Volume 12, Issue 6, pp 431–436 |
3) Sunku et al. A primary care approach to pediatric gastroesophageal reflux. JAOA,
Vol 100, No 12, Supplement to December 2000, p11-15
4) Rachel J. van der Pol, Marije J. Smits, Michiel P. van Wijk, Taher I. Omari, Merit M.Tabbers, Marc A. BenningaEfficacy of Proton-Pump Inhibitors in Children
WithGastroesophagealReflux Disease: A Systematic ReviewPediatrics, 2011 May; 127(5):925-35
5) Mattos AZ, Marchese GM, Fonseca BB, Kupski C, Machado MB. Antisecretory treatment for pediatric gastroesophageal reflux disease – a systematic review. Arq Gastroenterol, 2017. v. 54 nº 4 Out/Dez, 271-280.
6) Mark Safe, Wei H Chan, Steven T Leach, Lee Sutton, Kei Lui, Usha
Krishnan.Widespread use of gastric acid inhibitors in infants: Are they needed? Are they safe? World J Gastrointest Pharmacol Ther 2016 November 6; 7(4): 531-539 ISSN 2150-5349 (online) © 2016 Baishideng Publishing Group Inc. All rights reserved Salvatore, S. and Y. Vandenplas, Gastroesophageal reflux and cow milk allergy: is there a link? Pediatrics, 2002. 110(5): p. 972-984.
7) Cavataio F, Carroccio A, Iacono G. J Milk-induced reflux in infants less than one year of age. Pediatr Gastroenterol Nutr. 2000;30 Suppl:S36-44.
8) Iacono G, Carroccio A, Cavataio F, Montalto G, Kazmierska I, Lorello D, Soresi M, Notarbartolo A . Gastroesophageal reflux and cow's milk allergy in infants: a prospective study. J Allergy Clin Immunol. 1996 Mar;97(3):822-7.
9) Semeniuk J, Kaczmarski M. Acid gastroesophageal reflux and intensity of symptoms in children with gastroesophageal reflux disease. Comparison of primary gastroesophageal reflux and gastroesophageal reflux secondary to food allergy. !5 Didde Thorsted Case 1 DO PEAD PANTA RHEI Adv Med Sci. 2008;53(2):293-9. doi: 10.2478/v10039-008-0053-5. Abstract.
10) Ghaheri BA. Breastfeeding Improvement Following Tongue-Tie and Lip-Tie Release:
A Prospective Cohort Study. Laryngoscope, 127:1217–1223, 2017
11) Manuscript Aerophagia Induced Reflux (AIR) in Breastfeeding Infants with Ankyloglossia and Shortened Maxillary Labial Frenula (tongue and lip-tie).Teddy Performances
12) Kotlow,L. Infant Reflux and Aerophagia Associated with the Maxillary Lip-tie and Ankyloglossia (Tongue-tie). Clinical Lactation, 2011, Vol. 2-4, 25-29
13) Kotlow L. Infant Gastroesophageal Reflux (GER): Benign Infant Acid Reflux or just Plain Aerophagia? International Journal of Child Health and Nutrition, 2016, 5, 10-16
14) Scott A. Siegel. Aerophagia Induced Reflux in Breastfeeding Infants With Ankyloglossia and Shortened Maxillary Labial Frenula (Tongue and Lip Tie). Int J Clin Pediatr. 2016;5(1):6-8
15) Alcantara J. Et al . Chiropractic care of a pediatric patient with symptoms associated with gastroesophageal reflux disease. fuss-cry-irritability with sleep disorder syndrome and irritable infant syndrome of musculoskeletal origin. J Can Chiropr Assocv.52(4); 2008 DecPMC2597889
16) M. GemelliL. UlbrichtE. F. R. Romaneli. Evaluation of Gastroesophageal Reflux in Infants Treated with Osteopathy Using the I-GERQ-R Questionnaire. XIII Mediterranean Conference on Medical and Biological Engineering and Computing 2013 pp 1067-1070 . Part of the IFMBE Proceedings book series (IFMBE, volume 41)
17) Hayes NM, Bezilla TA. 2006 Incidence of iatrogenesis associated with osteopathic manipulative treatment of pediatric patients. J Am Osteopath Assoc Oct;106(10): 605-8
18) Ingram J, et al. The development of a tongue assessment tool to assist with tongue-tie identification. Arch Dis Child Fetal Neonatal Ed 2015;0:F1-F5. doi: 10.1136/archdischild-2014-307503

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Response of Plagiocephaly to Pediatric Osteopathic Treatment: A Case Study

Text: *Didde Thorsted*

Written and signed patient consent form was obtained

Key words: Plagiocephaly, Paediatric, Osteopathy, Infant, Treatment

Abstract

Introduction: This case report will discuss the role of pediatric osteopathic treatment in solving plagiochephaly in an infant

Case Presentation: The mother of an 8 weeks old infant presented her infant for osteopathic treatment with a diagnosis of Plagiocephaly. The mothers complaint also included lack of cervical mobility, interrupted sleep, excessive intestinal gas and excessive crying. Previous unsuccessful treatment involved stretching and
positioning the infant on a beanbag.

Management and Outcome: A course of 5 osteopathic treatments was applied over a period of 3 months. Consisting of spinal adjustments adapted for infant use, cranial osteopathic techniques, facial and muscular release techniques, visceral mobilization and mobilizing exercises for home use. Using caliper measurements to asses CVAI notable improvements were attained throughout the treatment period with normalization of head shape and ear position.

Discussion: This case showed an improvement on the plagiocephaly after osteopathic treatment . The Caliper is accessed to be an efficient tool when measuring cranial asymmetries but it is still depending on the preciseness of the therapist 1). Osteopathic treatment is tailor made for each individual and therefore a golden standard for treating this diagnosis is challenging to set.

Introduction:

Since the "back to sleep" to prevent SIDS was introduced the amount of infants presenting with plagiocephaly has risen 2). The use of helmets versus manual treatment is a topic of great interest. Some articles points to that natural skull growth will correct the skull as well as a helmet intervention 3) others that both manual stretching and the use of pillows can be a solution for plagiocephaly 4). With the knowledges that the condition "can effect health outcomes related to growth and development, vision, hearing and oral health" 5) and that it is a marker of elevated risk for neurodevelopmental delays when evaluated on The Bayley Scales of Infant Development III (BSID-III) 6) , it seems evident that more effort should go into researching methods to remedy the problem. Studies show effect of osteopathic intervention 7) This case study is not comparative but a presentation of the effect of osteopathy on plagiocephaly and support the findings of Lessard et al.

Case Presentation:

An 8 week old infant presented for pediatric osteopathic treatment for the diagnosis of plagiocephaly.

The Mother had a good pregnancy both physical and mentally, was well nourished and physically active throughout the pregnancy. The delivery was a home birth with natural onset week 40+2 with no medical intervention. The Infant was born after 7 hours labour, in water, after a 15 minutes pushing period.

The Mother reported that the head was round and fine at birth. The onset of the plagiocephaly was gradual. The infant also developed a favorite side and an aversion of lying prone. The Mother could manually turn the head but the infant turned it right back. She had previously been advised to stretch the infants neck, do tummy time and position the infant on a beanbag. She had applied this treatment for 4 weeks without results.

The infant presented with a plagiocephaly dexter at level 3 with a: two quadrant involvement, moderate posterior quadrant flattening in the occipital region, an ear shift of 1 cm, no anterior involvement and CVAI 6.25. 8,9) or type II after Agenta 10). Other complaints included lack of cervical mobility, interrupted sleep, excessive intestinal gas and excessive crying.

The Infant was in good health, color, breathing, tone, contact and reflexes were all normal. When accessing the infants motor development in supine it presented with a full 8 weeks normal development with cervical rotation dexter. When testing supine position with cervical rotation sinister and prone position the infant presented with a development equalling 4-6 weeks with a clear cervical rotation dexter.

Palpation and form of the skull gave no suspicion to craniosynostosis but a dexter nonsynostotic plagiocephaly affecting the occipital parietal suture with slight bulging of the sinistre parietal region, anterior ear shift dexter with temporal and condylar compression dexter and membranous tension.

Restrictions were found in sinistre SI, sinistre concave lateral bending with apex in the thoracolumbar junction affecting the lower ribs and diaphragmatic ROM and extension of the spine in prone. Restrictions of upper cervical spine rotation sinistre, and light restriction of lateral bending dexter in the mid to lower cervical spine. Increased tone in cervical muscles and fascias. Fascial tension sinistre in the upper abdominal quadrant , IC valve and abdominal distention dexter.

Management and Outcome:

The treatment consisted of 4 treatments with a 2 weeks interval and one treatment 4 weeks after. Measurements were taken at the 1st, 3rd and 5th visit.

The treatment consisted of :

Manipulative release techniques for the SI joint, cervical spine and thoracolumbar junction. Mobilization of the SI joint, cervical spine, thoracolumbar junction, lower ribs, diaphragm, lower thoracic spine.

Soft tissue release and stretch of diaphragm, cervical muscles (with focus on SCM, small extensors and trapezius) and fascias, para spinal muscles, treitz, colon desendens flexura sinistre, upper part of radix mesenterica, IC valve and fascias of the upper abdominal quadrant. Soft tissue techniques of cervical and para spinal muscles.

Cranial techniques including Infant CBR , condylar decompression with oral fixation, lift procedure, five star membranous release, suture distraction, ear pull and remolding

Not all techniques were applied every time, but the use was based on the current findings at the time of the appointment.

The treatment was accompanied by home exercise and massage to increase mobility in the cervical and thoracic region. Additional advice was provided concerning holding, handling and feeding positions. The parents were also instructed optimal sleep position.

The crying and sleep were measured by the parents on a schedule (table A)

Cervical mobility improvement

At the second treatment the infant had obtained full rotation with cheek to surface to both sides, but a preference was still seen when sleeping, with lack of stimulation and

in prone position. Parents were given exercise to increase rotation in prone.
At third treatment the baby was seen to choose rotation sinistre willingly. A few times the infant was seen sleeping on the sinitre side. The mother also reported an improvement of mobility and strength in prone. At 4th and 5th treatment no preference were found passive or active.

Excessive crying, sleep and intestinal gas improvement. At the 2nd treatment the parents reported a rapid improvement in the excessive crying. The red mark (inconsolable) decreased over the first 3 days and the orange (consolable) also decreased between the two treatments to what the parents described as only a little more than normal for an infant. The green (sleep periods) were still frequent and disrupted with only a little improvement but were seen to correlate with the passing of intestinal gas. Probiotics were recommended.
At 3rd treatment parents reported normal crying with improvements in both sleep and intestinal gas. The infant still pressed a lot to pass gas but without crying.
At 4th treatment the crying was still normal. The sleep cycles were longer and with less disruption. The pressing had ceased. Probiotic intake were adjusted to every 2nd day.
At 5th treatment the crying, sleep and intestinal gas was no longer a problem. A light increase in gas was noted after the probiotic adjustment but was quickly normalized again. The Mother also reported a decrease in stools pr day from stool in every diaper to 3 times pr day and more effective feeding without interruptions.

Change in CVAI
2. Measure 4.70

Picture 1

3. Measure 3.10 (Picture I)

Kl.	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	1	2	3	4	5	6	7
Dag 1																								
Kl.	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	1	2	3	4	5	6	7
Dag 2																								
Kl.	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	1	2	3	4	5	6	7
Dag 3																								
Kl.	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	1	2	3	4	5	6	7
Dag 4																								
Kl.	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	1	2	3	4	5	6	7
Dag 5																								
Kl.	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	1	2	3	4	5	6	7
Dag 6																								
Kl.	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	1	2	3	4	5	6	7
Dag 7																								

Søvn Gråd kan trøstes Gråd utrøstelig Spiser = **S** Afføring = **A** Tis = **T** Reflux = **R**

Table A :Schedule translated from Anja Caers www.happybabycoach.com

Discussion

In this case a good effect was noted on the infants primary and secondary complaints with osteopathic treatment. The fact that osteopathy is more a treatment philosophy than a few specific manual techniques makes it hard to conclude what part of the treatment provided the results. A part of this philosophy is that the treatment is always tailor made to fit the unique individual and that we treat the specific findings instead of following a specific regime. Therefore a golden standard for treating plagiocephaly is hard to set.
This case demonstrates that a multiple angel approach combining osteopathic treatment with home exercise and advice had the desired effect on correcting the plagiocephaly and thereby eliminating the cosmetic problem as well as decreasing the risk of viserocarnial and neurodevelopmental problems. This study suggests to the possibility that similar patients may benefit from osteopathic treatment when suffering from nonsynostotic plagiocephaly.

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References:

1) Siegenthaler M.H. Methods to Diagnose, Classify, and Monitor Infantile Deformational Plagiocephaly and Brachycephaly: A Narrative Review. Journal of Chiropractic Medicine (2015) 14, 191–204

2) Mawji A, Vollman AR, Hatfield J, et al. The incidence of positional plagiocephaly: a cohort study. Pediatrics. 2013;132:298–304

3) Rowland K, Das N. Helmets for positional skull deformities: A good idea , or not ? The Journal of Family Practice, JANUARY 2015, Vol 64, No 1

4) A Prospective Randomized Trial on Preventative Methods for Positional Head Deformity: Physiotherapy versus a Positioning Pillow . Article in The Journal of pediatrics 162(6), January 2013

5) Steinmann L. et al. Nonsynostotic Deformational Plagiocephaly: Understand, Screen and Intervene. June 17 2014. www.medscape.com 1/11-2016

6) Speltz ML, Collett BR, Stott-Miller M, Starr JR, Heike C, Wolfram-Aduan AM, et al. Deformational plagiocephaly delays motor skill development in 6-month-old infants Case-control study of neurodevelopment in deformational plagiocephaly. Pediatrics 2010;125:e537–42.

7) Lessard S, Gagnon I, Trottier N. Exploring the impact of osteopathic treatment on cranial asymmetries associated with nonsynostotic plagiocephaly in infants . Article in Complementary therapies in clinical practice 17(4):193-8 · November 2011

8) Plagiocephaly Severity Scale, Children's Healthcare of Atlanta

9) Holowka M el al.Plagiocephaly Severity Scale to Aid in Clinical Treatment Recommendations.The Journal of Craniofacial Surgery, Volume 00, Number 00, Month 2017

10) Agenta L. Clinical Classification of Positional Plagiocephaly. The Journal of Craniofacial Surgery, Volume 15, Number 2, May 2004

Osteopathy in Sports Medicine – an integral part of the team

Text: *Martin Stav Engedahl*

Photo: Solveig Stav Engedahl

Osteopathy is increasing in sports. Osteopaths are working with elite athletes and public health in, professional and amateur clubs, and with athletes coming to the clinic. Working in sports is exciting, fun and challenging. It is an important job that should not be handled easily. As an osteopath working with youth, elite or professional sports you have a great responsibility as a part of the medical team.

You are a health professional

Whether you are working as the only health professional or working in a medical team you are first of all a health professional. As a health professional you have certain responsibilities. The main task is to take care of the athletes and be the link between the trainer and the athlete in health-related issues.

To be a successful sports and exercise clinician you need qualifications in sports medicine. Both athletes, coaches, managers, parents, the sports medical team and others have high expectations to sports clinicians. In addition to this, you need exceptionally good communication and collaboration skills (1, 2). It is also essential to have good knowledge of the sport you are working with. If you understand the physical demands, the technical aspects and the mentality of the sport, you will be better prepared to understand possible causes of injury, how to prevent them and how you can contribute to the rehabilitation (3).

Working in a team

When working in sports medicine you are always part of a team. The team might be small and with you as the only health professional working with coaches, managers and athletes, or you might be part of a sports medicine team with a team physician, physiotherapist, psychologist, masseur and others (2, 4, 5). Anyway, you must understand your role as an osteopath as part of the medical team. Sports injury rehabilitation requires an interdisciplinary approach including both medical and performance team (Figure 1) (2, 5, 6). It is crucial for effective rehabilitation that everyone working with the athlete have clearly defined roles and are cooperating for the best of the athlete (6). It is important to establish what is expected from you as an osteopath as part of the sports medical team.

The athlete is an important part of this team as well and should always be included in both discussions and decision making (2, 6). Educate and inform the athlete, discuss different issues regarding the injury and rehabilitation with the athlete and let the athlete take part in the decision making. Including the athlete in the decision making will make a greater commitment to the plan and the athlete will feel ownership to the process. Shared decision making will also empower the athlete to take charge in process, have confidence to rehabilitation and adhere to plan (5, 6).

The athlete in focus

Every athlete is a unique individual. As sports clinicians it is important to develop a good relationship with your athletes. Mutual trust and confidence are of great importance. The athlete must feel they can confide in the clinician and be confident in advice they get. The clinician must be sure that the athlete will be honest and comply with advice they get (2).

As health professional working in sports we offer a unique competence for our athletes. Our job is to put the athlete's health first. We cannot expect neither the athletes themselves, coaches, managers, parents or others to do so. The athlete always wants to compete and will sometimes play through severe pain and functional limitations. Coaches and managers are responsible for the team's results and want to use the best players available (5, 6). If the athlete says she or he can play despite injury and pain, coaches often will let them. Someone needs to be on the athlete's side. Someone needs to make the unpleasant decisions. That someone is you.

Osteopathic reasoning in sports medicine

As osteopaths, we add something different to the sports medicine team. Reasoning based on the five conceptual models is a good starting point and gives an overview over the injured athlete. Combining this with evidence-based practice is truly biopsychosocial reasoning (6). Osteopathic reasoning creates an understanding of the complexity of the athlete's problem and should guide the treatment approach (7). From the reasoning it is important to define both modifiable and non-modifiable factors, and how to manage the modifiable factors (8). As part of an interdisciplinary rehabilitation team the osteopathic treatment is a part of the puzzle working for the same goal (Figure 1). The osteopath should be included in the rehabilitation process from the start. As an osteopath it is necessary to understand how the osteopathic treatment can enhance the rehabilitation and contribute to a safe and effective process to return to sport and performance.

Biography

Martin Stav Engedahl is an osteopath and physiotherapist with a Master of Science in sports physiotherapy from The Oslo Sport Trauma Research Centre (OSTRC).

He works as a assistant professor at Kristiania University College. He has in more than 10 years worked in elite sports for both youth and adults. He mainly worked with the Norwegian junior national team in ice hockey and with the Norwegian male national team in floorball. He has also worked with elite teams in both ice hockey and floorball and has participated as part of the sports medicine team in several international championships.

In addition to this, he contributed to the development of Fit To Play (no. Skadefri) and Get Set – Train Smarter (an evidence-based resource developed for anyone who engage in or facilitate sport. Fit To Play provide information on common sports injuries, injury risk factors, and specific injury prevention exercises for the sport of choice)

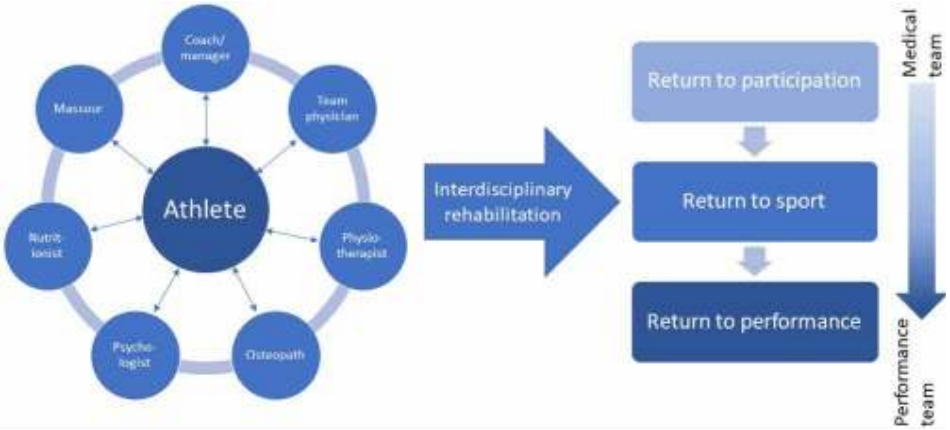

Figure 1. The interdisciplinary approach to sports injury rehabilitation. The athlete is at the centre of the process with the athlete, sports medicine team and performance team working together to optimize a safe and effective return to sport and performance. The responsibility for the rehabilitation and training should gradually shift from the medical team to the performance team when the athlete is returning to sport.

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References:

1. Ekstrand J, Lundqvist D, Davison M, D'Hooghe M, Pensgaard AM. Communication quality between the medical team and the head coach/manager is associated with injury burden and player availability in elite football clubs. Br J Sports Med. 2019;53(5):304-8.
2. Ardern CL, Glasgow P, Schneiders A, Witvrouw E, Clarsen B, Cools A, et al. 2016 Consensus statement on return to sport from the First World Congress in Sports Physical Therapy, Bern. Br J Sports Med. 2016;50(14):853-64.
3 Bahr R, Krosshaug T. Understanding injury mechanisms: a key component of preventing injuries in sport. Br J Sports Med. 2005;39(6):324-9.
4 Hainline B, Derman W, Vernec A, Budgett R, Deie M, Dvořák J, et al. International Olympic Committee consensus statement on pain management in elite athletes. Br J Sports Med. 2017;51(17):1245-58.
5. O'Sullivan K, O'Sullivan PB, Gabbett TJ. Pain and fatigue in sport: are they so different? Br J Sports Med. 2018;52(9):555-6.
6. Caneiro JP, Alaiti RK, Fukusawa L, Hespanhol L, Brukner P, O'Sullivan PP. There is more to pain than tissue damage: eight principles to guide care of acute non-traumatic pain in sport. British Journal of Sports Medicine. 2020:bjsports-2019-101705.
7. Grace S, Orrock P, Vaughan B, Blaich R, Coutts R. Understanding clinical reasoning in osteopathy: a qualitative research approach. Chiropr Man Therap. 2016;24:6.
8. O'Sullivan P, Caneiro JP, O'Keeffe M, O'Sullivan K. Unraveling the Complexity of Low Back Pain. J Orthop Sports Phys Ther. 2016;46(11):932-7.

International Osteopathy Research Leadership and Capacity Building Program

Text: *Robert Shaw*

The program is designed to provide research support and help to develop research leaders in the field of osteopathy. The intention is that this will support the development of a research culture within osteopathy. These could be a crucial steps towards raising awareness of the profession, and provide better inter-disciplinary healthcare communication.

The key benefits of this program are:

- Production of peer-reviewed manuscripts raising awareness of the profession both nationally and internationally.
- Creation of a group of osteopathy-focused researchers.
- Helping develop the confidence, experience and skills for a next generation of osteopathy research leaders.
- Developing a sustainable research culture nationally with international connections

The program was opened up for applications at the end of 2019 and there were 40 applications from around the world and 14 have now been chosen. The group is made up of a mix of nationalities from Australia, Brazil, Canada, Italy, New Zealand, Sweden and UK.
The program will initially run over three years. There is one five day residential event every year held at University of Technology Sidney (ATS), Australia. This involves formal input from guest speakers and senior academics from both ATS, and the wider osteopathic and health-care research community. They have experience of organising a similar successful and now self sustaining program for Chiropractors.

The idea is that participants develop their own research ideas, and work together in groups to answer these questions thus sharing the work load. The overall aim is to produce a sustainable international osteopathic leadership group.

Covid-19 has of course had an impact on the program. The residential planned for June 2020 has had to be postponed. It may not now happen until 2021. However, we had our first Zoom meeting on 20 May 2020 to introduce ourselves (see Zoom picture of participants below). It is a diverse group with some of the leading osteopathic researchers from around the globe. There are a lot of mutual interests and a wide range of expertise. As we will be unable to meet up in person, we are going to meet over Zoom and start to develop research questions. The next meeting is scheduled for December this year.

Robert Shaw
PhD, Program Leader, Skandinaviska Osteopathögskolan, Göteborg, Sweden

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Osteopathy – A natural fit

Text: *Øystein Tronstad*

Henrik Askjem has been working with professional cyclists for several years. In the world of professional cycling, osteopathy is as natural as water bottles and sports bars.

– I did not have very specific plans, but it was my goal to work with cycling. I like the variation and I am not suited to work at an office all day. It was a bit random at first. I had some connections within cycling and one of the coaches had noticed that I was studying osteopathy. He asked me if I wanted to come along for a trip, and now I have been working with the national team since 2016, says Norwegian osteopath Henrik Askjem.

From bike to bench

Pro cycling has had a resurgence in Norway in recent years with athletes like Thor Hushovd, Alexander Kristoff, Edvald Boasson Hagen and Kurt Asle Arvesen making a name for themselves all over Europe. For Askjem it all started on the saddle before he got on to the other side of the bike handle.

– It is a very classic story. I was doing the sport myself and enjoyed cycling. When I got a knee injury, I had a quality experience going to an osteopath for examination and treatment. That is how I got into osteopathy myself.

From his work with pro cycling he has experienced how common it is for team and riders to benefit from osteopathic care.

– On a professional level it is so established, especially in our sport. When I meet riders from countries like Switzerland, Italy and France, they are all familiar with it. Often it is their primary muscle and health resource back home.

Not yet authorized

The Norwegian association Norsk Osteopatforbund (NOF) has been fighting for authorization for quite some time. Askjem believes the profession would benefit from being authorized in Norway.

– It could make it a bit more known and accepted. There are not that many osteopaths here compared to like physical therapists, so it is important that we get the information out there and let people know who we are and what we do. I am certain that we, with our approach, are a good addition to the other health professions.

A small part of a big job

Traveling is a natural part of working with elite sports, so is almost everything else. Kai Lexberg, Askjems point of contact with the Norwegian National Team, says it is a complex job and not necessarily for everybody.

– The typical areas for cyclists are the hips, neck, knees and the back, but you have to be open to the fact that there is so much more to it than doing the treatments. Driving the car, preparing food and bottles, washing clothes, there are many tasks to be taken care of so that the team can function the way it needs to. For Henrik it is an advantage that he knows the sport himself, how the riders think and what it takes, says

Lexberg who became aware of the benefits of osteopathy because his brother was an early student.

– Every professional team has at least one osteopath. In my mind osteopathy looks at the entire system, It is not «just» a massage» and that is perfect for cycling. It is easy to just look at the spot that is bothering you, but at times we need to address where it is coming from too. With cycling there is a high total load. At the same time it is different from contact sports like handball or football.

Communication is key

When you work in the field of professional sports medicine there are many factors and points of view to take into consideration, like athletes, media, coaches, sponsors, sports directors and other health professions. Of all the details the one that Askjem highlights is communication.

– Some physical therapists are very hands-on, others focus more on the training part. The same applies for osteopaths. We also need to consider that some parts, like the cranial and visceral osteopathy, are not as established or accepted among other professions. Again, the way we communicate and explain is so essential.

When I got a knee injury, I had a quality experience going to an osteopath for examination and treatment. That is how I got into osteopathy myself.

The small adjustments

According to Lexberg the athletes are really pleased and appreciate getting a full treatment, when needed. One of the top Norwegian cyclists today is Carl Fredrik Hagen. In the 2019-edition of the Grand Tour Vuelta a España he finished in 8.-place. It is the best overall finish by a Norwegian athlete in a Grand Tour.

– I did not know much about osteopathy before I entered a high level of cycling. You know the title «physical therapist», but after some years you get familiar with the distinct professions. I think there should be room for everybody, different methods for different individuals. For me, osteopathy is a natural part of the team. It keeps my body prepped and ready.

What Hagen wants and needs depends on the condition of his body that particular day. A Grand Tour race lasts for three weeks. It can be frying sun or windy and rain. The riders can crash and there is little time for rest. It is safe to say that the small details matter.

– Luckily I have not had many injuries the last seasons. It does not have to be a problem if you ride with a «skewed» hip for a race, but if you do that over an entire season it could be a problem. Injury prevention is of course important. So is assisting the restitution process, says Hagen who uses the phrase «fine-tuning».

– One day I could be doing a time trial stage where you are extremely tense in the aerodynamic position, then it is back to the road the next day. Time is also limited so it is about «fine-tuning», small details or something you can work a bit on to bring out the last percent.

Henrik Askjem
Age: 29
From: Tønsberg, Norway
Osteopath: Sandefjord Fysikalske, Norwegian National Team Cycling, Uno-X Pro Cycling Team

– There are many different relations within a cycling team. You can be skilled but not fit into the group. Communication is key. It is crucial to know the sport and to be able to explain things in more ways than one. It is a different story if you are working with a 17 year old athlete compared to 35 year old who is doing his last championship. You have to establish a bond with the athletes and make them trust you. Explain your expertise so that they actively can seek you out for assistance. Manual therapy can be a broad subject. If you are part of a medical team you need to have respect and understanding for the variety of professions and therapists.

Osteopathy for professionals and amateurs

Over the year Askjem has worked with the Norwegian National Team, different Pro Cycling Teams, the private sport school NTG Kongsvinger and at the clinic Sandefjord Fysikalske.

– It is a bit different to work with a professional athlete compared to the everyday patient. You might have to explain things in another way for the «normal» patient. With professional sports you also have a different focus and perspective on performance. The cyclists know their bodies really well. If they have been riding for several years it is more common with problems related to stress and overuse. It is rarely acute, says Askjem who graduated as an osteopath in 2017.

He then spent time building relations and experience within the community, held presentations and talked to coaches and people who worked in the field of cycling.

– The education was great and I felt that I had the tools I needed to start working. But, it is also a field where one door will open ten new ones. You have to implement what you learned at school with sports medicine and the unique premises and demands of the sport. And you need some patience. You cannot start at the highest level, but build from the ground up. Experience, modesty and hard work will get you far.

Øystein Tronstad
Osteopathy student and journalist in Norway

The Birth of the first Osteopathic Master's Program based in Northern Europe

Text: *Robert Shaw / Sandra Rinne*

The pathway to achieving a proper recognition of osteopathy as an independent and developing profession, a master's level (EQF level 7) qualification has long been seen as a necessary step. Relevant qualifications within a sound educational framework are the foundation of being a serious and worthy healthcare profession. Europe-wide only a few institutions have been able to offer an academic masteŕ s degree so far. There have been few possibilities for osteopathic graduates to continue their path in the academic world.

During the last decade, the cooperation between SKOHS and Metropolia consisted among others of exchanging examiners for the final clinical exam and cross-evaluation. The collaboration intensified further through the validation process of the program in Gothenburg. For many years the dream to create an international masteŕ s programme in osteopathy existed. It was included in the long-term plans and it was encouraged by both the CEN standard as the OsEAN audit. Both institutions were recently audited by the Austrian Standards Institute and again encouraged to pursue this endeavour. However, the creation of a masteŕ s programme based in Northern Europe has long remained but a dream. This year the opportunity opened up as the Skandinaviska Osteopathögskolan, Gothenburg, Sweden and the Metropolia University of Applied Sciences, Helsinki, Finland, joined forces to create a unique program designed for practising osteopaths.

There are many valid reasons for building this brand-new program. The curriculum has been developing over the course of a year. Both institutions conducted surveys with good response rates, and we were thus able to take into consideration the feedback and wishes of alumni and the need of the profession for renewal and development. The program will provide a springboard for osteopaths in gaining the skills needed to engage in the fields of research, education, business development and healthcare collaboration.

Over a two-year-period students will have the exciting opportunity to explore and develop their osteopathic career potential. There will be the possibility to delve into the latest thinking around osteopathic theory. Students will then explore new ways of incorporating these theories into contemporary osteopathic practice. This program will play a significant part in developing a rich research culture within our profession. We will then be able to develop a stronger professional identity and raise awareness of osteopathic healthcare within society.

Three common threads of modern day osteopathic practice run throughout the program:

Clinical: exploring explanations for osteopathic treatment effects within an evidence informed and critical thinking perspective, and advanced practitioner skills. Experienced practitioners will lead courses that will enable students to engage in these processes.

Research: building a constructive forum for open inquiry, discussion and development through expanding knowledge on research methods and skills and creating a master's thesis. A team of experienced research supervisors will help support the thesis process.

Service and management: developing an integrated, safe, person-centred approach to osteopathic service as a whole including skills in leadership, management and service design. The program is fortunate to draw upon the skills, and experience of the Master's Degree Programme in Health Business Management team. Courses of this thread will be together with the Health Business Management- students from Metropolia.

All three aspects are considered essential to develop the osteopathic profession's ability to communicate and work with other healthcare professional both nationally and internationally.

Evidence informed practice approach is the bedrock of the program. The rationale here is that there is a necessity for the osteopathic profession to reflect upon its theoretical models and integrate the most recent and relevant research. In order to meet these goals, the programme aims is to build a constructive forum for open inquiry, discussion, and development of novel theoretical constructs. Students will be encouraged to explore, and critically reflect, on explanations for osteopathic treatment effects within an evidence informed perspective.

It is expected that students will draw upon evidence from other disciplines. They are supported in this endeavour from the beginning of the program. There is a strong emphasis on developing good competence in research and development. These competences are supported throughout and culminate in a Master's Thesis.

Our aim is that graduates from this programme will have gained a valuable insight into what they can achieve and what their professional potential is, a valuable group of people to refer to and continue sharing knowledge with and that they will feel competent and encouraged.

Originally, the program was intended to be a combination of on campus meetings and online/virtual learning. In the face of the new situation we all are in, the focus has shifted to creating a valuable online experience for everyone.

This novel master's program may help shape the future of osteopathy in the Nordic Countries and beyond and we hope it will be an exciting experience for both students and staff alike. Stay tuned!

Robert Shaw
PhD, Program Leader, Skandinaviska Osteopathögskolan, Göteborg, Sweden

Sandra Rinne
Head of Osteopathy, Metropolia University of Applied Sciences, Helsinki, Finland

Master's Degree Programme in Osteopathy

The first of its kind in the Nordic countries, developed in collaboration between Skandinaviska Osteopathögskolan, Göteborg, Sweden and Metropolia University of Applied Sciences, Helsinki, Finland.

This is a 2- year program (90 ECTS). The common threads that run throughout the curriculum are clinical, research, service and management aspects of modern day osteopathic practice.

As well as providing a focused continuing professional development opportunity, there are other benefits with participation in this program:

- International networking forum for osteopathic graduates, which will encourage further exchange and collaboration
- Higher degree studies become possible for example to study at doctoral level
- An advantage to those practitioners who want to develop a teaching career
- Opens up opportunities for other positions in the health care sector.

For updated information, please visit:

https://www.metropolia.fi/en/academics/masters-degrees/osteopathy

Or contact us via email:

info@osteopathogskolan.se
LauraLee.Kamppila@metropolia.fi

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Digital leap in a workshop setting - preparing to adapt

Text: *Eero Palevaara*

Every spring the Finnish osteopathic association organizes its annual general meeting coupled with a 3-day post-graduate course for the members.

This year, in March 2020 we obviously could do nothing else but cancel our plans due to the Covid-19- situation. We, like most of the world were caught by surprise. The disappointment was especially outstanding, as we have never had to cancel a course before. We were not prepared for any alternative approaches.

Now, after almost a year down the road we have turned our eyes to next spring. This time want to be ready, no matter what the situation will be, so we decided that we'll ask our teachers to ready themselves to be also "digi-ready" if needed.

To be prepared, we decided to test how it goes and perform a test run of on-line practical teaching. To do that, we had the amazing facilities at the Metropolia University of Applied Sciences with all the up-to-date equipment- maybe even too modern for us- in our hands. The space looked like a real tv- studio that we could project the video from. We used the Zoom Webinar as our software. I also had a colleague at hand who assisted me by reading all the comments from the attendants during the session, which was super helpful.

Attendants were informed that they could do this practical training from there offices or homes, as long as they had an internet connection, a training table and someone to practice on.

The start was a bit weird when you can't see the people behind their treatment tables. "Can you hear me...? Can you see me...?" Good! Let's go! When teaching without seeing the participants you don't know how they are doing. You have to describe everything you do in an even more detailed and clear way than you would do in a face-to-face situation.

The teaching went really well and this on-line teaching is something that we all should consider, at least for a back-up. With a large space and good camera-angles the practical demonstrations were easy to follow. It also makes me wonder if we should add the possibility to participate via streaming to all our courses.

Pros:

• Teaching without interuptions (but do remember to stop and ask questions)
• Via online streaming you can reach people who can't otherwise join the live teaching
• It is possible to have a recording from the session and use it later (If you don't mess with the microphones like we did)

Cons:

• It is harder to teach without eye- and body contact with the participants
• Talking only to a camera can be difficult
• You have no idea if the participants join the lesson or join the nacho plate

Remember:

• Test the devices, connections (audio/video), camera-angles and so on in advance
• Schedule wisely- be effective but remember to take brakes and avoid too long periods of passive sitting
• Involve participants with questions and make it interactive.

Tips:

• Ask for help if you need support with the digital equipment
• Learn how to use Zoom etc applications in advance
• There are profesionals who can run your stream. You will save costs when going on-line, so why not hire a pro if you can?

It is hard to say how the future looks like. But now we are more ready and more comfortable with the online options. This kind of streaming could be used in a larger conference space when dividing people in smaller groups in case for instance the corona guidelines restrict larger gatherings in the long run. Let's see how 2021 will look like!

Eero Palevaara
Osteopath,
Board member Finnish
Osteopathic Association

The EFFO: united across borders

Text: *Frances Cholerton & Hanna Tómasdóttir*

The continued development of a sense of community is an essential feature for the growth, recognition and regulation of the osteopathic profession. In Europe the body working towards a greater vision where, regardless of borders, osteopathy stands together is the European Federation & Forum for Osteopathy (EFFO). Hanna Tómasdóttir, President of the EFFO, sets out the inner workings of this 'organisation of organisations' and how through shared learnings and values, a greater vision for osteopathy across Europe is being inspired.

An organisation of organisations

It took over a century, from osteopathy's arrival in Europe in 1913, to the establishment of the European CEN Standard on Osteopathic Healthcare Provision (EN16686) in 2015, for the profession to have a wider sense of acknowledgement through a standardisation for high quality clinical practice, education, safety and ethics for Osteopathy in Europe. This European Standard was significant for our profession to set a benchmark of care expected of osteopaths in Europe, as well as to generate a core framework for the community that exists today, and has already been proven to be very useful when it comes to regulation.

The regulation process in Denmark was, for example, assisted by the establishment of the World Health Organisation (WHO) Benchmark for Training in Osteopathy, published in 2010, and the CEN standard. These two benchmark documents were of great assistance to the Danish government in their determinations, and for the Danish Patient Safety Authority, where they served as a reference for basic level of education and as an overall qualification framework for the osteopathic profession. Both standards are used as target standards by EFFO members and many of the osteopathic education providers across Europe.

Established in March 2018, the EFFO was born when its two predecessors - the European Federation for Osteopaths (EFO) and the Forum for Osteopathic Regulation in Europe (FORE) merged. The EFFO is currently made up of professional associations and regulators from 22 European countries, with two associate members (Canada and Israel) - as only those based in Europe can be considered full members - and represents over 25,000 practitioners in these countries.

The four pillars of the EFFO

Our organisational model is member focussed, and member driven. The Board of the EFFO includes six members from six separate member countries and consists of: Hanna Tómasdóttir (Denmark), President; Jonathan Bailey-Teyletche (UK), Vice President; Alex Boon (Belgium), General Secretary; Dimitri Boulenger (Greece), Treasurer; Richard Weynen (Germany), Research; Lluís Horta (Spain), Board Member and Maurice Cheng (UK), Chief Executive.

The Board is supported by four member driven Working Groups that represent the four pillars of the EFFO: Education, Regulation, Research and Communication & Marketing. These four Working Groups work towards a deeper understanding, mission and objectives of their specialist areas, sharing their contribution and progress at our meeting, so that collectively we can reach decisions about what the EFFO does, and how we can best support the profession, and the members.

Meetings that embrace our community, our vision and our goals

At our twice a year meetings, set up by the Board, we aim to select a location which would benefit from our representation and support for the osteopathic profession in that country. For example, our Spring Conference and Annual General Meeting this year in March was held in Lisbon, Portugal and the 2019 Autumn Meeting was held in Madrid, Spain. By holding our conference alongside meetings with local politicians and stakeholders we are able to support the lobbying effort to further assist promotion, regulation and recognition of osteopathy in the respective countries.

Our Autumn Conference and General Meeting in September 2020 was planned to take place in Oslo, Norway, but had to be held online due to COVID-19. Each meeting is attended by one or more national representatives of the respective organisations who contribute to their knowledge and skillset. The structure

General meeting in Madrid 2019

of those meetings are set by the Board with contribution from all four Working Groups. At our last meeting, for example, the Education Working Group presented a draft statement about where the EFFO would like to encourage and support the development of osteopathic education to our membership. This statement is about the importance of maintaining and developing high standards for osteopathic education, as described by CEN for Type I and Type II programmes. Furthermore, the education programmes should meet national requirements for recognised qualifications, where applicable. The statement was approved by the EFFO membership and will be implemented as our vision and aim for education within our profession.

At the same meeting the Regulation Working Group introduced a draft of a document that provides an overview of regulation of the osteopathic profession in Europe. This draft was shown to all our respective membership who were able to provide their comments and ideas. Yet to be published, we are aiming for it to be a shared, editable and translatable publication to reflect the changing face of the regulation of the profession. These member-driven contributions from our Working Groups acts as a valuable toolkit to all our membership who are working to improve standards and recognition or gain regulation of our profession in their home countries.

Our annual meetings are therefore much more than just a platform for networking. We are sharing and learning about our profession; improving Public Relations; brainstorming future projects, establishing visions, aims and goal setting; and sharing our ultimate passion: osteopathy. We are being opened-minded and embracing all our membership in a helpful, constructive manner. This shared nature of working is at the heart of what we do and proliferates the community of osteopaths that we are today.

Through COVID-19: closer than ever

During this year, as an organisation we have come closer together. At the start of lockdown, when a lot of osteopaths in Europe were forced to close their clinics, we set up a Task Force, consisting of all the four Working Group Chairs; Laura Lee Kamppila (Finland) Chair for the Communication & Marketing Working Group, Chiara Arienti (Italy) Chair for the Research Working Group, Tomas Collin (Norway) Chair for the Education Working Group, Hanna Tómasdóttir (Denmark) Chair for the Regulation Working Group and Maurice Cheng (UK), representing the EFFO.

The Task Force, who communicated and worked on a daily basis during the first many months, established live webinars, provided the national representatives with education in Social Media, and created our own YouTube Channel, where you can watch many of our webinars. Beside these contributions the EFFO Board has held regular online Network Members Meetings with the aim of sharing national updates on restrictions, news and implications for osteopaths, and to inspire and engage our membership.

Follow us

The European Federation & Forum for Osteopathy on Facebook

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Through navigating the changing face of governmental guidelines and restrictions we came closer together in an adverse, unpredictable global situation never before seen.

Expanding our European reach and regulation

In total there are 44 countries in Europe, and one of the EFFO goals is to one day be formed by the whole European community, because we need this greater community to support each other and for the profession to evolve and thrive. Eleven countries in Europe have currently achieved regulation of the osteopathic profession on a governmental level. Those countries are: Denmark, Finland, France, Iceland, Lichtenstein, Luxembourg, Malta, Portugal, Switzerland, United Kingdom, and most recently, Norway!

The way forward for the profession is to be fully regulated and recognised as a primary healthcare profession in all European countries. The more we are able to represent osteopaths together, the stronger we are.

Being an active part of the European Federation & Forum for Osteopathy supports the promotion and regulation of the osteopathic profession, as a recognised primary healthcare profession, nationally and internationally, while contributing to our thriving and united European community.

Frances Cholerton
Freelance journalist

Hanna Tómasdóttir
President of the European Federation & Forum for Osteopathy

Do chronic pain patients experience personality changes as their condition persists?

Text: *Hilmar Þór Arnarson*

Pain is very subjective as it cannot be seen, but the consequences from living with pain are very objective, they can be seen. But does pain change your personality, or can a person change their personality to increase their well-being and happiness?

Personality is something everyone has, and it defines who you are. How a person reacts to situations, makes decisions, and lives their life. People perceive pain in different ways according to their personality. But what is the biggest deciding factor in how people experience pain, and how do some people develop chronic pain while other do not? Do people with certain personality traits cope better with pain and are less likely to develop chronic pain?

Personality has been shown to change when associated with chronic illness or pain (Jokela, Hakulinen, Singh-Manoux, & Kivimäki, 2014). People who suffer from chronic pain have the tendency to develop depression and might focus more on the things they cannot do, such as everyday house work, the inability to attend children's activities and dependency on other people to assist with various chores that are considered normal everyday chores to others. This can lead to resentment towards the chronic pain, patient guilt, hopelessness and anger towards the pain from the person living with the pain (France, 1987; Herr & Mobily, 1992). Sadness can be confused with depression but is not the same. Sadness is a human emotion that everybody can experience in spite of their personalities and depression is mental illness that could develop from long term sadness and chronic pain, for example.

Biopsychosocial model proposed by Engel 1977 (Inerney, 2016) shows how a person can develop as a chronic pain patient, where many factors psychological, social and biological play an important role. One aspect of this model are psychological factors which contain personality elements such as how people perceive pain, their thoughts and actions. The fear avoidance model is another model introduced by Lethem et al in 1983 (J. W. Vlaeyen & Linton, 2000) and explains differences in how people can develop chronic pain and differences in the perception of pain. According to the fear avoidance model, people can take two directions. When pain is experienced, the person shows no fear, confronts the situation and recovers. These people do not typically develop chronic pain. The other direction is where pain is experienced which leads to catastrophizing the situation and pain related fear. It stops them from being active and they become disabled and depressed. The circle then repeats itself and the person focuses more on the pain and becomes less active and depression becomes more set in (J. W. S. Vlaeyen, Crombez, & Linton, 2016).

Shuchang et al (2011) concluded in their study that chronic pain patients showed more negative emotions like anger, frustration and resentment. All these factors reinforce pain reception and negative thoughts which affect people's personality and are related to neurotic behaviour. People with introverted personalities were also shown to have larger reactions to psychological stress which influenced spinal loading and function of the biomechanics (Guimond & Massrieh, 2012).

Patient's beliefs in chronic pain is considered to be an important factor in the ability to control the pain and the situation. The belief that activity might aggravate the symptom prevents the person in engaging in rehabilitation treatments. This kind of behaviour can increase disability and lead to resentment and depression, which contributes to further problems.

Hudson and Fraley (2015) studied whether personality can change, for example for an introverted person to become more extroverted. In their conclusion it is possible to do so, if a person wants to make changes to their personality, they can make desired changes if they put in the effort. Other traits can be changed, like agreeableness and conscientiousness (Hudson & Fraley, 2015). According to the study, people can make changes to their personality as they desire. Agree to make the change and challenge yourself to step out of the comfort zone or the environment you have created.

Personality has a significant input to chronic pain and depression, according to the evidence. People with extroverted personalities are considered less likely to develop chronic pain. They are considered to have better posture, be more relaxed, open to changes and more acceptable to different situation and therefore less likely to present fear avoidance (Kendall, McCreary, Provance, Rodgers, & Romani, 2005). But it is not that simple to label people as introverts and extroverts, as extroverts can be introvert at some level and vice versa. Very few are complete introverts or extroverts according to Carl Jung's theory (Aquinas, 2006).

From the osteopathic point of view, it helps to be able to assess the patient's personality to provide the best care possible and engage the patient in the path for better health. Therefore postural changes and openness of the patient could be the most efficient tools to foster personality changes in the patient.
It has been shown that personality can change in people with chronic pain. Introverted personality and neuroticism are more likely to develop chronic pain, so it might be assumed that that chronic pain exaggerates these kinds of personalities. Extroversion, openness, agreeableness and conscientiousness personalities are less likely to change towards negative personalities and develop chronic pain. On the other hand, people with more negative personalities can adapt to more positive personality traits. Therefore, it can be assumed that personality does not change from positive to negative with chronic pain. Chronic pain might reinforce negative emotions in those who score higher towards introversion and negativity. Further studies might be needed to confirm this, but would be complicated to measure for the fact that it is hard to predict who develops chronic pain before an accident or injury occurs, although there seems to be a window for an assessment and intervention to do so.

Hilmar Þór Arnarson
M. Ost

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DISTRIBUERT AV POSTEN NORGE
NORGE P.P. PORTO BETALT
B

Faglig oppdatering

Text: *Styret i NOF*

NOF har vedtatt at det må drives faglig oppdatering minimum 48 timer i løpet av de siste tre år. Vedtaket er fattet av årsmøtet og kravet står nedfelt i forbundets vedtekter. Styret er pålagt av årsmøtet å sørge for at medlemmene gis mulighet til å loggføre sin faglige aktivitet på en sporbar og sikker måte. Det er utviklet en egen modul i vår medlemsdatabase (Regweb) hvor det enkelte medlem selv kan gå inn og logge faglig aktivitet. I tillegg kan man her endre firmainformasjon, adresser og andre opplysninger.

Faglig oppdatering og utvikling inngår i kunnskapsbasert praksis og er samtidig nedfelt i kvalitetssikring av helsepersonell som sådan. Nasjonalt og internasjonalt stilles det krav til fagutøvelsen og denne er i stadig endring og utvikling. Våre krav er ment å stimulere til at den enkelte osteopat fortsetter sin kontinuerlige og livslange læring.

Faglig oppdatering kan romme mange former for aktiviteter. Kriterier er at den faglige aktiviteten skal være relevant for den enkeltes helsefaglige yrkesaktivitet som osteopat og at den skal være mulig å dokumentere/spore. Det er den enkeltes ansvar å logge sin aktivitet på en slik måte at man ved kontroll kan se hva denne innebærer og på forespørsel kunne dokumentere dette i form av f.eks. kursbevis, karakterutskrift, betalt deltakeravgift etc. Vi anbefaler derfor at man tar vare på og lagrer relevante dokumenter.

Registrering av faglig oppdatering

Pålogging skjer enten via forbundets nettside. Velg «medlemsinnlogging» og angi brukernavn og passord. Under «personalia» finnes link for logg av faglig aktivitet.

Ved eventuelle påloggingsproblemer kan også følgende link brukes: *https://osteopati.regweb.no/api/v1/example?page=remote_index*

Under følger eksempler på faglig oppdatering. Merk at listen ikke er uttømmende.

Ta kontakt med oss dersom du er i tvil om din planlagte aktivitet teller.

- Kurs – både i regi av NOF og andre tilbydere
- Seminar, frokostseminar, åpne forelesninger – både i regi av NOF og andre tilbydere
- Konferanse - både i regi av NOF og andre tilbydere
- Videreutdanning/etterutdanning – f.eks. Universitet, høyskoler, private institusjoner m.fl.
- Publisering – f.eks. IJOM, Osteopaten m.fl.
- Undervisning og foredrag – f.eks. på konferanse, fagdag m.m.
- Fagdag - både i regi av NOF og andre tilbydere
- Fagseminar i regi av pasientorganisasjoner eller andre aktører innen helse
- Digitale kurs, foredrag og Webinar
- Fagmøter på arbeidsplassen, kollokviegrupper, workshops med kolleger, hospitering, kollegaveiledning, klinisk veiledning
- Case-report/case-study
- Litteraturstudier

Regler for timetelling

Kurs og aktiviteter
- Fagdag: 6 timer
- Årsmøte: 3 timer
- Kurs, heldag: 6 timer
- Kurs, halvdag: 3 timer
- Kollegaveiledning/kollokvie etc: oppgi antall timer
- Annen faglig oppdatering: oppgi antall timer

Vennlig hilsen,
Styret, NOF

HUSK DEADLINE FOR BIDRAG TIL OSTEOPATEN NR. 1/2021 20. FEBRUAR 2021.

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