



DENVER
CHIROPRACTIC
CENTER

The Dr. Glenn Report

Don't put up with pain.

www.denverback.com 303.300.0424

March 2011

Why almost getting sued was the best thing that ever happened to me

In 1998, Denver Chiropractic Center sprang to life after I found out I was being sued. Long story short – the wacky chiropractor that I was renting space from sued me for breaking my lease. He x-rayed each patient and told every single one that they needed a minimum of 100 visits! Every single one. He constantly berated me for not “believing” in his approach, so after 2 months I bolted.

A couple of well structured letters from a young lawyer friend made it go away (thanks Cheryl!), and I decided to strike out on my own.

In those first few years I had good intentions, but I didn't have a clue about how to run a business. I came about as close as you can get to bankruptcy without actually filing. In fact, if it hadn't been for the inexplicable decision by Wachovia bank to raise the limit on a maxed-out credit card, I would have been there. Ah, 1999, I was happy to see you pass.

12 years later, things are looking up.

2010 was a great year for us. In fact, it was so good that some weeks we had a little trouble keeping up with the demand. As a result, we've expanded the clinic, adding a physical therapy center. Most of you will now be able to do progressive functional rehab exercises

– prescribed by me – in our office. In March, a second ART certified chiropractor, Dr. Jeff Stripling, will join our practice. Jeff's an active guy who likes running marathons, cycling, and all things outdoors. I think he'll fit in nicely.

Along with the new doctor will come some of the things you've been asking for over the last decade or so. For starters, we'll be offering expanded hours (both earlier starting times and later last appointment times). We'll also offer Saturday morning hours two Saturdays per month (with Dr. Stripling).

There's more- I'll be teaching Saturday morning small-group workshops right here in the clinic starting this spring. Some of the topics will include exercise classes, injury prevention classes, stress management classes, kettlebell workshops, a return of the popular “Training for trainers” classes, triathlon specific classes, and more.

You can sign up for our email newsletter to stay up to date.

I want to thank all of you for supporting us over the years. Your support and loyalty has made all of this possible. Without you this practice doesn't exist. We're looking forward to providing you with great care and great service in 2011 & for a few more decades to come.

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This test will tell you a lot about yourself...

I spent a recent December weekend hanging out once again with some very smart physical therapists in Brighton. We were becoming certified practitioners of the Functional Movement Screen. (Many of you may recall that this past August I went to Brighton to learn about the Selective Functional Movement Assessment. Despite their seemingly similar names, the two are different. End digression.)

I've been using the Functional Movement Screen for years, but decided to get officially certified because it's becoming a key part of my practice-finding the underlying dysfunctions that end up producing pain. It's about fixing the problem, not just getting rid of the symptoms.

The Functional Movement Screen (FMS) is a system of 7 movements that are scored on a 3-point scale. 3 is good, 1 stinks, and 2 is somewhere in between. A total of 21 is perfection. Research shows that athletes (of any level) who score 14 or less are three times more likely to get injured than athletes who score a 15 or more.

The idea is that you identify your worst functional movement and then work to correct it, thus improving your score. You then do follow up screens to determine what you need to work on next.

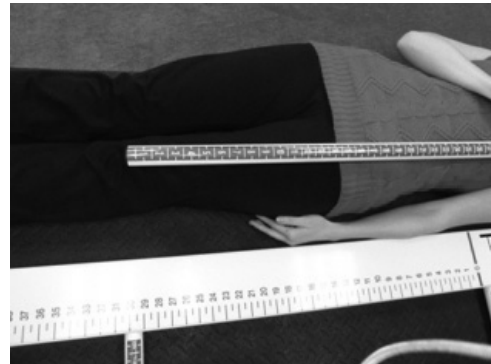
So I'm going to have you check yourself on the movement test considered most important – the Active Straight Leg Raise.

At first glance, this may seem like a test of hamstring flexibility. It is, and more. It also assesses your active hip flexion, and your ability to maintain hip extension on the other side. These are three very important fundamental ranges of motion.

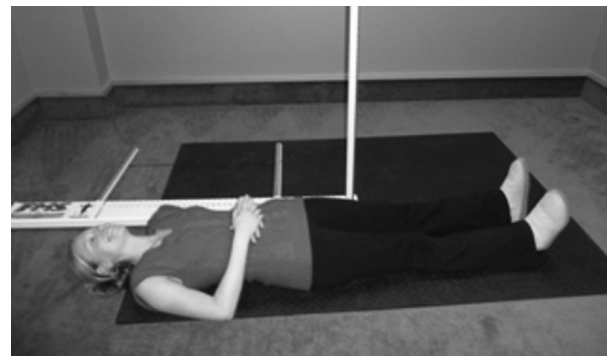
Poor performance on this test means you're

more likely to experience one or more of The Big Three- back pain, hip pain / sciatica, and IT band / knee pain. So the Active Straight Leg Raise is a good place to start. It requires a stick, an optional tape measure, and a buddy. For purposes of the description here, you are the one who's evaluating the test and your buddy is the one performing the test.

Have your buddy lie down on his back. You need to identify two points on your buddy, the kneecap and the ASIS, or point of the hip. (Start on the left side.) The hip point is that bony thing at the waistline right above where the hip flexes. Measure the distance between the two points to find the middle of the thigh. The middle of the thigh is the reference point for this test.



Once you've found the middle of the thigh, stand the stick up to mark the spot.



Your buddy is still on his back. (If you are a woman and your buddy is a guy, he's probably making smart-ass remarks at this point because he knows he's about to do a really bad job on this thing. Try to take pity on him.) Your buddy's head must stay on the ground, his arms at his sides, and his palms UP, to avoid cheating.

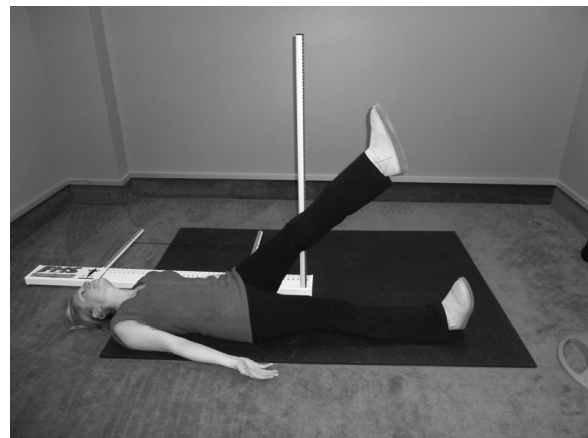
So, your stick is at mid thigh on the outside of the left leg. Have your buddy raise the left leg – with the knee straight – as high as he can. The right leg MUST stay flat on the ground. If your buddy can get his left ankle (the bumpy bone on the outside of the ankle) above the stick, he gets a 3. If he can get his ankle between the stick and the left kneecap, he gets a 2. If he can't raise the ankle past the level of the left kneecap, that's 1.



Erin gets a 3 for this effort, her heel is above her mid-thigh



With her heel between the stick and her right knee, Erin gets a 2.



Erin couldn't raise her foot past her right knee, so she gets a 1. Boo.

Now test the other side. When scoring, a 3 on each side is ideal. 2 on each side is OK. 1 on each side is bad. Different scores on each side is considered an asymmetry, and that's bad. Frankly, if you score less than 3's you should come in and do the full Functional Movement Screen. The idea is to figure out which Functional Movement you score lowest on and take steps to improve it. We've developed rehab protocols to improve each pattern and improve your overall score. This reduces your likelihood of getting injured.

So, what are you going to do about it?

In the meantime, here is a basic progression we've developed to correct low scores on the Active Straight Leg Raise. The general idea is to progress from isolation exercises to integration exercises to functional exercises.

Of course, the first step to improving poor performance on the Active Straight Leg Raise is releasing any scar tissue in the hamstrings and hip flexors with Active Release (Dr. Glenn is standing by). Then add in the following therapeutic exercises.

In reality, a corrective exercise program is tailored to you, based on your personal condition and your score on the Functional Movement Screen, from which the ASLR was extracted.

Single Leg Contract-Relax Stretch (isolation). Start on your back. Your right leg is the one doing the stretching, so with a slight bend at the knee, bring it up until you feel a bit of a stretch in the hamstring. Grab a hold of the leg as shown and push the leg into your hands for about as long as it takes you to take 3 slow deep breaths (this is the contract part). When you exhale that third breath, relax the hamstring and slowly stretch further by bringing your leg closer to chest. This takes advantage of 2 types of reflexes, the relaxation that comes with a deep exhale and the relaxation that comes after a prolonged contraction. Together, these two activities help your nervous system learn a new resting length for the hamstring. Repeat 3-5 times on each side.

Single leg stretch with opposite terminal extension (isolation/integration). While we would normally use an isolated leg stretch for a few days, for our purposes here we'll move right into an integration exercise. Here, we're basically combining a the contract-relax hamstring stretch above with active hip extension on the other

side. So start with your left leg flattened out leg onto the ground while gently pulling the other one into the stretch. As you start to feel the right leg reach a stretch, actively push the left leg into the ground. Pay attention to what each leg is doing and hold the extension during the stretch on that third exhale. Do 3 reps on each side.

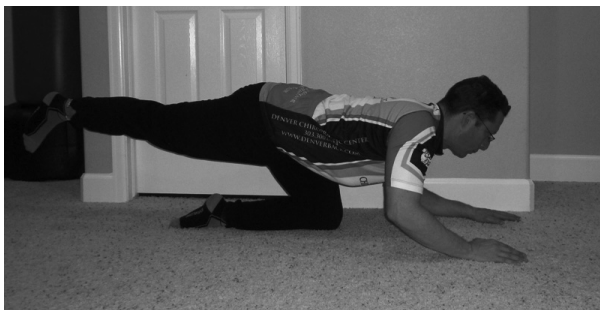


Combining hip extension with hip flexion on the opposite side is a pattern that's fundamental to many sports. This rehab activity helps restore and reinforce the fundamental pattern. It's a stepping stone to the more complicated activities that follow.

Quadruped hip extension with opposite flexion (integration). Taking the idea of combining opposing hip flexion and extension farther, we have this excellent little move. Get down on all 4's. Extend your right leg straight behind you making sure you fully engage the right glute.



While maintaining the extension of the right hip, drop your left hip further into flexion- moving your whole body toward the floor. You must keep that right glute contracted and that right leg straight. Watch what happens with my left (bent) leg below. It's tougher than it looks.



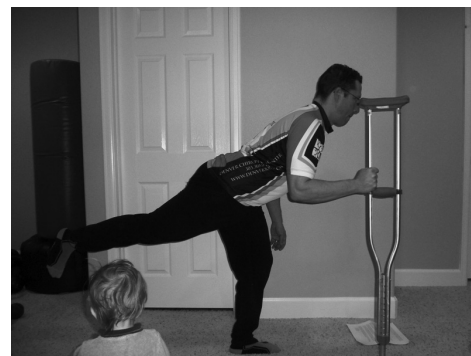
This exercise lets you improve your neuromuscular control and directly improves or maintains your Active Straight Leg Raise score and helps protect your back, your hips, and your knees. Remember to work both sides, 3-5 reps.

Stiff-Leg Deadlift with stick (functional pattern). After a couple of weeks of training in the above rehab exercises, it's time to up the complexity. Now you'll combine the opposing hip flexion and extension with a whole body balance challenge. Hold a stick in your right hand to help with balance (if needed). First, you'll tilt slightly forward, arch

your back slightly and kick your right leg back into full extension.



Continue moving forward toward the floor by flexing forward at the hip joint. The end range is when your body is almost parallel to the ground.



It's once again important to maintain hip extension in that right hip. And of course, switch legs. Do 3 sets of 5 reps.

As you can see, we've progressed the basic pattern of opposing hip extension and hip flexion and created a greater demand on both legs. This is the essence of the progressive rehab that we've added to our treatment plans at Denver Chiropractic Center. Once again, we've moved beyond simply treating symptoms, like pain.

We're looking to correct the underlying dysfunctional patterns that are the underlying cause of pain. This is what keeps problems from coming back over and over. If something's been hurting you, or if you just feel like certain movements feel restricted or "wrong," give us a call and come on in. 303.300.0424.

(BTW-Why am I holding a crutch? Well, it's Meredith's after her recent major knee surgery. Turn the page to find out more.)



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(* Cigna— Out of network, but welcome)



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What you can learn from my wife's very bad knee...

Many of you have been into the office over the last few months and you may have noticed Meredith (my wife) hobbling around on crutches.

Sometime in mid-January, Meredith had her second major knee surgery in the last 4 years. You see, when she was about 12, she broke her leg. As a young gymnast, she dismounted the balance beam with a back flip, stuck the landing, and snapped her femur. The shear force of the landing caused her femur to fail. **My father-in-law, who was there, to this day refuses to describe the sound it made.**

What followed was an ambulance trip to the hospital, an attempt to re-set the bone, failure of that attempt, and then a major-league open surgery to install pins to put the femur back together. Pins were sticking out of her leg. A full leg cast for 3 months followed. Then more surgery to remove the pins. She has a huge scar on the inside of her right leg from all of that.

As you can imagine, that leg has some abnormal mechanics. Looking at her right leg, you can see that the inside of her quad

(the Vastus Medialis) is noticeably atrophied. It's like part of it is missing.

So, when Meredith reached her 20's, she started doing marathons and half marathons. Her leg always hurt to a certain extent while running, but she ran through it. Simply ignored the pain. This went on for years. As her 20's gave way to her 30's, the knee pain slowly became worse and worse.

She had her first appointment with my cancer surgeon (that story is on the Articles page of denverback.com) Cynthia Kelly 4 years ago. Both the lateral and medical menisci were damaged from the running. Cartilage at the end of the femur was badly degenerated. Bone spurs developed on the back of the patella. Dr. Kelly fixed all as best she could. Another surgery would be needed in 4-5 years.

That brings us to now. Dr. Kelly once again repaired both menisci, ground down some bone spurs, and this time threw micro fracture to the femur to try to re-grow cartilage. A total knee replacement looms in 7-10 years.

So what's the moral of this story?

The question this may bring to your mind is, "Should I be running (or biking, or lifting, or swimming, or skiing, etc) through pain?"

The truth is that now that I'm getting older, and my patients are getting older, the cumulative damage from these things we do in our 20's and 30's really starts to take a toll on our 40's and beyond. And so it comes down to management.

If I had known Meredith during the running years, I would NOT have told her to stop running. But I would have encouraged her to implement an aggressive management program – ice, stretching, strengthening, work on her stride, foam rolling, and regular Active Release sessions with me. Regularly.

She would have had to do something almost every day to minimize the collateral

damage from the sport she loved. It would have been a pain the ass to do all that work, and yes, cost some money to do all that Active Release. But I can assure you that she wishes now that she would have done that. Dr. Kelly has told her no more running on that knee. Sure, she can ride a bike or swim, and even 'power walk.' But all you runners out there know that ain't good enough for a runner.

So the moral of the story is this – don't ignore those problems that you train through. Manage them. Next month I'll tell you a little more about why helping you athletes – regardless of level – stay in your sports is so important to me. But for now, if something has been nagging at you, call us, come in and start making sure you don't lose your ability to run or ride or lift or ski or whatever.