Spring 2017

ISSN: 2208-4533

IN HAND

The Newsletter of the RSI and Overuse Injury Association of the ACT
Supported by ACT Health and the Southern Cross Club

October 2017

News & Events

Pain and Your Relationships

Hosted by the Chronic Conditions Seminar Series

Speaker: Randolph Sparks
When: Thursday, 19th October, 7:00pm
Where: SHOUT, Collett Place, Pearce
Cost: Free, all welcome

RSI Association AGM

Living with RSI: What works for you?

When: Thursday, 9th November, 12:30pm
Where: Room 2.09, The Griffin Centre, 20 Genge St
Cost: Free, all welcome and lunch provided

Helping people with RSI:

- *Telephone information service*
- *Referrals*
- *Guest speakers*
- *Events and social gatherings*
- *Treatment options*
- *Ergonomic devices*
- *Voice-operated computing*
- *Workers' compensation*
- *Tips and tools for daily life*

Find ways to relax without leaving your room … page 12

In This Issue

Notices

"Pain and your Relationships"

A talk by Randolph Sparks for the Chronic Conditions Seminar Series

Clinical psychologist Randolph Sparks will talk about how you can meet the challenge of keeping your relationships strong when you are in chronic pain. Randolph works in private practice as a psychologist and is a part-time lecturer in the School of Psychology at ANU. He has a strong interest in the area of chronic pain and many years of experience of working with patients with overuse injuries.

When: Thursday, October 19, 7:00pm
Where: SHOUT, Pearce Centre, Collett Place, Pearce
Cost: Free, all welcome

Living with RSI: What Works for You?

Coming up next month is our Annual General Meeting. As well as giving you an update on our progress in the last year, we want to give members the chance to have an informal discussion about how you manage your RSI, and hear from others about what they find helpful and effective.

So we invite you to come along, share lunch with us and tell us what works for you in dealing with your RSI. Feel free to bring along a tool, the name of a therapist or just an idea that helps you. Members of our committee will be there to share their ideas as well.

To help us cater, please RSPV by phoning us at 6262 5011 or emailing us at admin@rsi.org.au

When: Thursday, November 9, 12:30pm
Where: Room 2.09, The Griffin Centre, 40 Genge St, Canberra City
Cost: Free, all welcome and lunch provided

Please join our committee!

We need new committee members to us keep our organisation vibrant and relevant to your needs. As someone with RSI, you have valuable insights that can help us improve our services. It's not a big commitment – just one meeting every six weeks for about an hour. The meetings are informal and friendly, but we get a lot done! New members are always made very welcome.

If you'd like to find out more, ring us on 6262 5011 or email us at admin@rsi.org.au.

If you have an asterisk next your name on your address label, that means it's time to renew your membership. Please renew on our website or fill in the form at the back of the newsletter

Bits & Pieces

From the Director

Thanks to all the members who attended our event, “Getting on Top of Pain”, on July 21. The evaluations were very positive and many people wrote that they took away ideas for managing their chronic pain in different areas, including approaching the doctor differently, new approaches to anxiety and depression and some strategies to try to improve function. We are very grateful to our sponsors and to our speakers for their help in making the event possible.

We recently made a submission to the enquiry into the employment of people with disabilities in the ACT. It’s good to be able to report that some of our key points were included in the final recommendations, including important recommendations to make sure that procurement guidelines “for ICT products purchased by the ACT Government require accessibility features as a standard” and that “the ACT Government ensure Shared Services ICT provides timely support for reasonable adjustments in the IT system including hardware and software enhancements.” These are good first steps in enabling staff to use voice-operated software without the problems they currently experience.

Ann

Utilities Concession

The ACT Government recently combined the energy and utility concession and the water and sewerage rebate into a single Utilities Concession of up to $604.00. This means that more renting households are eligible for the same level of concession as homeowners. To be eligible, you must hold a Centrelink concession card, such as a pensioner concession card or a Low Income Health Care Card. If you believe you may be eligible or want to find out more, contact your energy provider for more information.

Next Step

Next Step is a new program designed to help Canberrans with mild to moderate mental health conditions, such as depression, who are unable to access Medicare. Next Step is a stepped care model, which means that clients are offered different treatments depending on their needs, without having to get a new referral. They can be either stepped up or stepped down to get the most appropriate treatment. Gaylene Coulton, Canberra Health Network Executive, said "Canberrans with mental illness can now access Next Step which provides greater flexibility for them to access services that will meet their changing needs." CatholicCare are leading the project and clients can get face-to-face care from mental health professionals for six to eighteen sessions. You can find more information at next-step.org.au

Administrative Appeals Jobs for the Boys and Girls

Well-paid posts at the Administrative Appeals Tribunal are among the goodies handed out to MPs who lost their seats at the 2016 election, according to a recent article in the Sydney Morning Herald. Two Liberal MPs who lost their seats at the last election were given $200,000 a year jobs with the Tribunal, as was Labor figure Anna Burke. Previously, former Labor Minister Duncan Kirk was made president of the Tribunal at $400,000 a year. Whether such political appointments make the tribunal as independent as it should be is open to question.

Three D Jobs

Have you heard of a "three-D job"? That's a job that's dirty, dangerous, and demanding. And that describes the conditions at poultry processing plants, where workers are under intense pressure to process more than 100 chickens per hour and face a rate of injury one and a half times higher than the average for all US workers. Forty-two percent of US poultry plant workers in a 2012 study had evidence of carpal tunnel syndrome and it's such unpleasant work that local workers often don't want to do it. That means the work is left to migrants with little knowledge of their entitlement to safe working conditions or workers' compensation.

Research in Brief

LOW-LEVEL LASER THERAPY

Does low-level laser therapy work for carpal tunnel syndrome?

This question was investigated recently by the Cochrane collaboration. Unfortunately, they found that the evidence on the this therapy was "limited and very low-quality". They concluded that there was insufficient evidence to show whether low-level laser therapy was more or less effective than a placebo or ultrasound, simply because of the lack of good quality studies. The authors called for researchers to make sure future research was high-quality. "The existing very low-quality evidence does not need replicating", they said.

Low-level laser therapy for carpal tunnel syndrome Chen Y., Zhao C., Ye G., Liu C., Xu W. 2016

NO PAIN, NO GAIN?

Should exercises be painful in the management of chronic musculoskeletal pain?

Exercising past the point where pain begins is a strategy recommended by many therapists for patients with chronic musculoskeletal pain. The idea behind it is that this could help patients to lean that "hurt does not equal harm" and minimise so-called catastrophizing and "fear-avoidance".

But does it actually work? Researchers looked at seven trials with 385 participants to find out. They found that, in the short term, painful exercises were slightly more effective but in the mid to long-term they had no advantage. Putting it in a rather negative way, the researchers concluded "pain during therapeutic exercise for chronic musculoskeletal pain need not be a barrier to successful outcomes." So if a therapist pushes you to do exercises that cause pain, pointing them in the direction of this paper could be useful.

Should exercise be painful in the management of chronic musculoskeletal pain? A systematic review and meta-analysis
Smith B., Hendrick P., Smith T., Baterman M., Moffatt F., Rathleff M., Slfe J., Logan P. 2017

THE VALUE OF SECOND OPINIONS

How often do second opinions result in a change of diagnosis? Surprisingly, as many as 88% of diagnoses can be refined or completely changed with a second opinion according to a study from the Mayo Clinic, an American non-profit medical practice and medical research group.

In 21% of cases examined, the diagnosis was completely changed, potentially saving a lot of money wasted on ineffective treatments and preventing harm to the patient. Only 12% of patients left with the same diagnosis that they came in with.

It’s worth noting that the study only looked at patients who came into the Mayo Clinic actively seeking a second opinion from experts, implying that they were reacting poorly to treatment or had a condition that merited being examined by expert and experienced doctors. It’s unlikely that the average doctor is misdiagnosing common ailments at this rate, so you shouldn't necessarily distrust your GP's diagnosis, especially if it's a more common illness.

However, it’s a good reminder that doctors are only human and whenever they diagnose you with a serious condition; it’s probably worth getting a second opinion.

Extent of diagnostic agreement among medical referrals Van Such M., Lohr R., Beckman T., Naessens J., 2017

The Opioid Epidemic

From February 2018, you won't be able to buy any opioid medications over the counter including Panadiene, Mersyndol, Nurofen Plus and some cough medicines. Why?

Over the period 2008-2014, there was an 87% increase in prescription opioid deaths in Australia. In the US, the Drug Enforcement Administration has stated "overdose deaths, particularly from prescription drugs and heroin, have reached epidemic levels," and nearly half of the deaths due to overdose in the US involved an opioid prescription.

Opioids used to be avoided

There's been a massive increase in opioid prescriptions from just 40 years ago, when "physicians and nurses were trained to give minimal opioids for pain, often even less than prescribed, unless death seemed imminent." This was due to a fear of addiction following the start of the 'War on Drugs' and high rates of heroin addiction in America.

In the 1980s, this mindset was challenged by Kathleen Foley at Memorial-Sloan-Kettering Cancer Center in New York. She published two papers that found opioids weren't addictive among small groups of cancer and non-cancer patients. "These articles, along with a one-paragraph 1980 letter reporting addiction to be rare among inpatients, became the rather fragile foundation of a 20-year campaign ... led by Foley" to make opioids more widely prescribed.

How did opioids become over-prescribed?

Since then, opioid prescriptions have skyrocketed. The most obvious candidates to blame for this are the drug companies that made and marketed the opioids and the doctors who over-prescribed them to patients.

Opioids were marketed aggressively by Perdue Pharma, (in Australia, Mundipharma), who began selling Oxycontin. It was advertised as a safe drug for managing chronic pain. They claimed it was "nonaddictive because the drug was [fully] released within the body over 12 hours," though it turns out they knew this wasn't true and the shorter release led to withdrawal symptoms.

Opioid-induced hyperalgesia

A peculiar issue that effects a small percent of patients on opioids is opioid-induced hyperalgesia. Hyperalgesia is a heightened response to even slightly painful sensations. Think of when you get a sunburn and your burnt skin becomes incredibly sensitive to pain: that's hyperalgesia.

Patients can become hypersensitive to pain when opioids activate instead of dulling the nervous system. This can happen with any dosage but generally it occurs if patients take high doses for an extended period of time. This means that taking opioids may actually increase a patients' pain.

The difficulty for doctors is that an increase in pain can be associated with opioid tolerance. The response to tolerance could be to increase the dose, but if the problem is hyperalgesia, higher doses would just make the problem worse.

Some U.S states are even attempting to sue pharmaceutical companies for causing the opioid crisis, likening it to the tobacco crisis in the '90s. The state of Ohio, where 793 million doses of opioids were prescribed in 2012, is suing several pharmaceuticals including Perdue Pharma. They claim that the companies "trivialized the risks of opioids while overstating the benefits of using them for chronic pain," but legal experts say the case is unlikely to be successful.

Doctors aren't altogether innocent either. Many doctors did massively overprescribe opioids, despite limited evidence for their effectiveness in managing long-term pain and concerns about addictiveness. However, Dr Andrew Kolodny explains that the evidence available was biased because the pharmaceutical industry withheld research. Doctors were also being told by the wider medical community, such as state medical boards, hospitals and respected doctors, that compassionate practitioners would prescribe opioids to reduce their patients' suffering and this created huge pressure to increase their prescriptions of opiods.

Why are opioids dangerous?

Opioids reduce pain by "attaching to and activating opioid receptor proteins ... When these drugs attach to their receptors, they inhibit the transmission of pain signals." However, the drugs also attach to receptors in the reward parts of the brain. This can produce euphoria, especially when the drugs are taken in higher doses, or crushed and injected so that the release of the drug is much faster.

Is Cannabis an Alternative to Opioids?

Given the increasing evidence that opioids cause more harm than benefit to patients with chronic pain, it's worth looking at alternatives. Cannabis is one good option. A recent survey of nearly 3000 medical marijuana users found that 90% preferred marijuana over opioids for managing their pain. Professor David Penington says that while marijuana has some dangers to people under 25, it does have a place in pain management and can reduce opioid abuse.

There are some roadblocks in using cannabis though, says Penington. First, you can't have a double-blind trial for cannabis. Anyone who was given the real deal would work it out pretty quickly.

Second, cannabis can't be a normal prescription drug. "It contains a variety of components of variable potency and actions ... Consequently, cannabis has variable effects in individuals." This means you can't work out a safe dose for everyone based on data from a clinical trial. If the doctor isn't sure exactly how it will affect the patient, they can't prescribe it. This is overcome in some American states, though, where "the patient makes the choice to use cannabis following a medical consultation."

How does cannabis reduce pain?

Cannabis has two active ingredients: Cannabidiol (CBD) and d-9-tetrahydrocannabinol (THC). THC is responsible for the high that people get from smoking cannabis, so most cannabis sold to recreational users is higher in THC. CBD actually reduces the high, and is also responsible for suppressing nausea and pain. Both could have a place in medical cannabis use. Penington argues: "if a person in the late stages of painful cancer seeks the euphoria of THC, why should they not have it?"

Penington suggests that given the benefits of cannabis to people with chronic pain, and its lack of side effects compared to opioids, it should be used in pain management though strict regulation to make sure the cannabis is safe and effective is important.

Medical Cannabis: Time for Clear Thinking, David Penington, 2015

Patients with chronic pain are especially vulnerable to developing opioid abuse because they take opioids for an extended period of time. Their body then reduces its own production of opioids which allows tolerance to build up and leads to withdrawal if the dose isn't reduced gradually.

What should be done?

Unfortunately, the problem can't be solved by just stopping the prescription of opioids. They remain very effective as a treatment for short-term, acute pain. They also have a place in cancer treatment and palliative care. However, when it comes to chronic pain, research suggests that the risk is too high and the benefits are dubious at best.

One option is the development of opioids that are harder to abuse. A possible new drug, NKTR-181, is designed so that it can't be made to release quickly and it's being fast-tracked after positive results in a study on patients with chronic back pain. It differs from normal opioids because it has "low permeability across the blood-brain barrier" so it only affects receptors in nerves, not the ones in the brain that produce a high.

Key findings from the survey of nearly 3000 cannabis users from the University of California, Berkeley:

- **93%** said they prefer cannabis to opioids
- **92%** said cannabis' side effects were more tolerable than side effects from opioids
- **90%** said cannabis works well with non-opioid pain relievers
- **96%** said they need fewer non-opioid pan relievers when using cannabis
- **89%** said cannabis was more effective than non-opioid pain relievers

9 out of 10 Patients Prefer Cannabis Over Opioids, Pat Anson, 2017

Given the number of deaths in Australia and around the world every year, it seems that all paths are worth pursuing if they can limit the number of opioids being prescribed.

Support services are available for people suffering from chronic pain or addiction:
ScriptWise (03) 9909 2807
Pain Link helpline: 1300 340 357

Joseph Penington

The Ongoing Opioid Prescription Epidemic: Historical Context, Marcia L. Meldrum, PhD, 2016
The Atlantic — Are Pharmaceutical Companies to Blame for the Opioid Epidemic, Alana Semuels, 2017
Dr Andrew Kolodny, ABC's Lateline , 2017
Misuse of Prescription Drugs, National Institute on Drug Abuse, 2016
New Opioid Painkiller has Less Abuse Potential, Pat Anson, 2017

Need to carry things? Get a Robot.

If you have trouble carrying things, or just want to give your arms a rest, you could get some help from a robot.

The Budgee is a robot from Five Element Electronics. It follows an ultrasonic `pinger' that you keep in your pocket. and will follow you around carrying up to 20 kg of shopping or whatever you need to move. However, it costs $1400 — possibly excessive given it can struggle with some obstacles and be somewhat temperamental.

Currently under development by the Piaggio Group, makers of the Vespa, is the Gita. It forgoes the futuristic face of the Budgee and instead looks like a large wheel you can fill with your shopping. It only takes around 18kg but may be cheaper and more reliable .

"What do you do to help manage your pain?"

results from our survey at the Pain Symposium

AT A GLANCE

24%

said that they exercise

7%

said that they prefer to just relax

11%

said that they like to meditate or practice mindfulness

3%

said that they read

6%

said that they go to a physio

9%

said that they socialize and talk to friends

3%

said that they get acupuncture

4%

said that they focus on their work

6%

said that they find it helpful to learn more about pain

Dr Romil Jain: 'What You and Your Team Can Do'

On July 21st, Dr Jain was the keynote speaker at our event 'Getting on Top of Pain'. Here's a summary of his talk.

Dr Jain began his talk by pointing out that “There is no fix for chronic pain. It is about how we manage it.… We treat a person who is in pain. The first questions we ask ourselves are: Why does this person have chronic pain? What has happened to this person? What are the different contributors to this pain?”

Dr Jain said that there was a high prevalence of anxiety and depression in chronic pain patients and that this was a two-way street. “Chronic pain leads to depression and anxiety, and depression and anxiety increase pain. If we are treating only one thing at a time we are going to be only partially successful, (which is) the reason that we need a coordinated approach from different practitioners (including) pain psychologists, occupational therapists and physiotherapists.”

Dr Jain used a story to illustrate his point that medications by themselves are not the answer to chronic pain. “Say I own an old car and there is a noise from my engine.… I do not know what the problem is so I just increase the volume of my speaker (to drown out the noise). It happens again and again and by the year’s end my speaker is at full volume.” At this point, the car just won’t go any more. He went on to say that taking morphine-based medication is like turning up the volume of the speaker: it doesn’t do anything apart from masking the pain, in the same way the sound from the speaker hides the engine noise. “The only reason we give pain medication… is to give you a window of opportunity when your pain is going to be less and you can take part in other things that are going to help you,” such as a psychological-based therapy or a functional-based therapy.

> "Chronic pain leads to depression and anxiety, and depression and anxiety increase pain. If we are treating only one thing at a time we are going to be only partially successful"

“If someone comes to me and says, “I had an 8/10 pain score and my medications decrease it to 5 or six and I’m happy about that,” but it hasn’t changed your function, it hasn’t changed your mood, it hasn’t changed your sleep, it hasn’t changed your quality of life – that says I’m not successful. If I haven’t give importance to these parameters, I haven’t given you good service or proper treatment.”

Dr Jain prefers a biopsychosocial approach, in which other contributors to the pain are explored and treated. “We are not trying to treat chronic pain, we are trying to treat a person who is in pain and the impact of pain on their life”.

“A lot of the time my patients tell me “My other health practitioner tells me it’s all in my head”. How many of you hear this? It’s partially true and partially wrong. It’s partially true, in that if you didn’t have a head or a brain, you would not be here. And partially wrong, in that it implies there is nothing wrong and you are making it up. Pain is your sensory and emotional experience. It may or may not be associated with anything pathological. So you might have normal structures but still have pain because somehow your system has become sensitised. And it is our duty to find out why this is happening, how it became

sensitised and how we can help you get on top of it."

In the initial patient assessment at the Canberra Hospital Pain Unit as well as some of the subsequent ones, patients' family members are included for a multitude of reasons. "One is that your partner, or significant family members, want to help you and they don't know how…. Many times, they suffer in silence – they are also suffering along with you. They want to understand what is happening and they also give us very important information.… For example, when I ask a patient "how is your sleep?" they say "it's all right", and the relative says "not so – you toss and turn all night." I asked "how is your mood?" "Pretty good" – but the relative says "it's changed. It's cranky and short tempered." Dr Jain added that changes happen over time in a patient with chronic pain and impact on mood and personality, which the patient may not realise. So a partner can give very valuable information, which is why they're encouraged to come to the assessment.

"If you ask me… if a patient could do one thing out of the hundred things we offer what would it be? Would it be medications? Would it be a procedure? Would it be psychological therapy, functional rehabilitation or something else? What would it be if I had to offer only one thing? I would say pain education. There is nothing better than this.… In our pain clinic we call it JUMP: Journey into Understanding and Managing Pain."

"What would it be if I had to offer only one thing? I would say pain education. There is nothing better than this"

The JUMP program is a full day program, starting at nine and finishing about three. It covers what chronic pain is all about, including desensitisation and neuroplasticity. Dr Jain said that this kind of program is one of the most powerful tools in pain management and could be "one of the most productive days of your life if you are a chronic pain sufferer."

After the JUMP program, there are a number of elective programs available (see box below) . There is also an exercise-based program patients can access.

"We have a saying: "If you can't help yourself, then God cannot help you". So you have to take an active part in your management. If you want someone else to do everything for you, it is unlikely things will improve. But if you say, "I am willing to do my part, I am willing to take part in my rehabilitation and follow all your suggestions" then the chances of a better outcome are much higher."

Canberra Pain Clinic—Basic Facts:

- There is a nine-month waiting period for the initial assessment.
- Following your referral, there is a group medical assessment.
- There is a low intensity one-day program, a medium intensity program that is 8 days over six weeks and a high intensity program that is Monday to Friday for two weeks.
- Most of the programs are done in groups but there are some individual options.
- Following the program, you can take six or seven electives on topics like exercise, mindfulness and sleep.
- It's free, but you need a referral from your GP or a specialist.

What happens to injured workers who don't get better quickly?

A recent study followed almost 300,000 workers with long-term injuries to find out whether they were still working and how they were doing financially.

The study found quite a few differences between men and women. Men with long-term injury were significantly more likely to be out of the labour force and have lower incomes than women. However, when it came to arm, hand or shoulder injuries, women were disadvantaged. They were **less likely** to be in full-time employment than women with other long-term injuries and men with the same injuries.

Overall, it seemed that what helped women to stay at work was the more flexible working conditions that they achieved: part-time work hours, the opportunity to work from home and flexible start and finish times, all which are commonly seen in part-time employment. The article also stressed the importance of access to higher education after injury, as it made it easier to return to work, especially for women.

To summarise, the article suggests that changing our expectations about men's work could help them to stay in work after injury and promote recovery as well. Currently a whopping 660 000 Australians between the ages 45-64 are not in the labour force, costing us $12 billion dollars per year and highlighting the need for change in our workplace culture. By employing more men in flexible and part-time positions we could see more people engaged in the workforce who would otherwise struggle to return to work with an ongoing injury.

From our Facebook Page

Like our page on Facebook for regular updates and interesting articles

- Are sit-stand desks a good idea? Probably yes, as long as you sit as well as stand. Here's a report on the dangers of standing all day: *https://theconversation.com/standing-too-much-at-work-can-double-your-risk-of-heart-disease-83629*
- Here's a very readable article on the emerging, and much-debated, science of how acupuncture works, including for carpal tunnel syndrome and fibromyalgia. Some surprising stuff here! *https://www.theguardian.com/global-development-professionals-network/2017/sep/07/pains-and-needles-brain-scans-point-to-hidden-effects-of-acupuncture*
- Do you wake up in the middle of the night with painful tingling hands or fingers? Here are some good suggestions on how to prevent (and treat) night-time carpal tunnel symptoms: *https://www.wikihow.com/Sleep-with-Carpal-Tunnel-Syndrome*

Progressive Muscle Relaxation

At our recent pain symposium, psychologist Randolph Sparks gave a lively and interesting presentation aimed at helping people in chronic pain to live a full life. One of his key points was the importance of progressive muscle relaxation (PMR) as a pain and stress management technique. PMR has many benefits, both physical and emotional. It's been shown to be effective in many studies as a stress-management tool; recent research shows that, used regularly, it can lead to a decrease in measured levels of the hormone, cortisol, that's often associated with stress.[1]

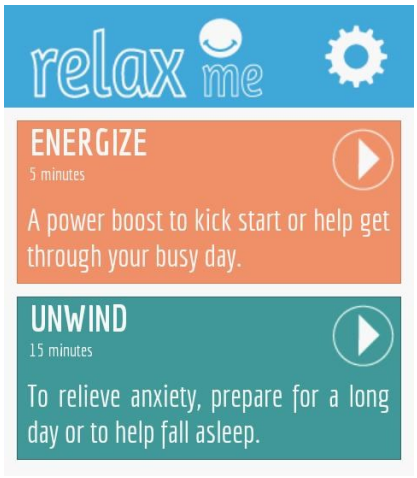
It's also very helpful in relieving the tight muscles associated with RSI and with chronic pain.

PMR is a technique in which you first tighten and then relax major muscle groups in a fixed order, breathing in as you tighten and out as you relax. For example, many PMR guided meditations start by having you tighten and relax your arms, then your shoulders, head and neck, chest, abdomen and legs in that order. Does the order matter? I don't think so, but it definitely helps if you get used to doing it in the same order every time.

PMR is not at all difficult or complicated. First, choose a time and a place where you won't be interrupted or disturbed, and turn off your phone. It's best to choose a time when you don't feel sleepy, as PMR can make you so relaxed you may go to sleep. (Of course, you can use it in bed at night when you **want** to go to sleep.) You will need to set aside about 10 minutes.

Lie down on the floor, with perhaps your knees and your neck supported by cushions if that makes you more comfortable. You can also sit up straight in a chair. If the room is at all cool, cover yourself with a light blanket – relaxation can make you feel colder.

The easiest way to carry out PMR is to have a voice guide, either through a CD, a You-Tube video or an app. "Relax-me" is a fairly basic PMR app that is free to download. You will also find plenty of free guided PMR scripts on You-Tube. The ABC also has a free guided PMR that you can download here: http://www.abc.net.au/radio/programs/classicflow/mini-meditation-progressive-muscle-relaxation/8596374; you can also find it by Googling 'ABC mini meditation'. What's really important is to get used to letting your muscles relax as you breathe out. Saying words to yourself such as "heavy", "loose", and "soft" as you breathe out can be very helpful.



Some people find tightening up their muscles uncomfortable, but that's not strictly necessary. You can just direct your attention to the muscles in question as you breathe in and then relax them as you breathe out. Or you can just imagine tightening them as you breathe in – that works too.

As you become accustomed to progressive muscle relaxation techniques, you will find that you can use your out-breath to relax muscles in all kinds of contexts. Instead of relaxing your entire body, you can focus on just one area. For example, if you become aware that your neck muscles are tight while waiting at the bus stop, you can use PMR to relax them. You can do short, focused PMR sessions while sitting at your keyboard at work and no one will notice.

PMR is also helpful in other ways. Because it encourages you to breathe deeply and slowly, it can help develop new healthier patterns of breathing. And learning what a relaxed muscle actually feels like can help us

to become aware that we are using more effort than is actually needed in everyday tasks and give our overworked muscles a break and a chance to recover.

In short, PMR is a technique that won't cost you a penny and can make a big difference in helping you to successfully manage both the pain and the stress of RSI.

Ann Thomson

[1]The Effect of progressive muscle relaxation on daily cortisol secretion
Chellew K., Evans P., Fornes-Vives J., Perez., Garcia-Banda G. (2015)

Frozen Shoulder: Fact or Fiction

According to a recent article in the journal, 'Physiotherapy', there's a big difference between what doctors believe about frozen shoulder and the facts. The classic story about frozen shoulder is that it has three stages: freezing, frozen and thawing. The 'thawing' stage implies that frozen shoulder will fix itself in time without the need for any treatment.

Conventionally, doctors believe that "a frozen shoulder progresses naturally through painful, stiff, and recovery phases to full resolution in time without treatment" says the main author of this study, Christopher Wong. He goes on to say that there is no evidence to support this theory of natural resolution and in fact the evidence from many trials directly contradicts it.

Why did the accepted view of frozen shoulder persist for so long in the medical literature? Wong says that it's hard to understand, given that the 'natural history' theory was based on just one article that's frequently cited in medical textbooks, research articles and reputable health websites. This research actually failed to show that patients recovered without treatment. In fact, "at least 25 of 41 subjects were still limited (in motion) even after years of non-treatment", according to Wong. He goes on to say that more recent evidence convincingly demonstrates "that without treatment motion does increase, though not fully, with improvements that decline with time."

"What is the impact of misinformation?" Wong asks. "For people with stiff and painful shoulders, a misinformed prognosis may lead to them not seeking care and hoping for a recovery that is doubtful even after many months of limitations. For physicians, assumption of a recovery without treatment may also lead to a wait-and-see approach that can prolong pain and cause functional decline for their patients." Misinformation could also lead to many patients doubting their own symptoms and being seen as malingerers by treatment providers.

The good news is that Wong goes on to describe a treatment protocol, including soft tissue mobilization, that he says is effective. He concludes: "It is time for misinformation about stiff and painful shoulders — known by some as frozen shoulder but more accurately referred to as adhesive capsulitis — to be corrected so that effective treatments can be found to restore pain free motion and function as early as possible."

Ann Thomson
Frozen Shoulder: fact or fiction? Body in Mind July 28, 0217

Tips and tools

Using a mouse can be painful but hard to avoid. Fortunately, there are some devices that can help you avoid using your mouse — or maybe get rid of it entirely.

Kensington Expert

The Kensington Expert is a 'Wired Trackball'. Instead of moving the mouse around your desk, you simply roll the ball with your fingers. It also has four buttons so you can do a bit more without switching between your mouse and your keyboard. Many people find the wired trackball puts less strain on their injury, but some find that it's just as bad as a normal mouse, so it's definitely worth trying one out before buying.

Pen and Tablet

If you find using a pen easier than a mouse, then a tablet like a Wacom might help. Tapping on the tablet with the pen clicks on the corresponding point on the screen. The high-quality tablets can be quite expensive, though.

Cirque SmartCat AG

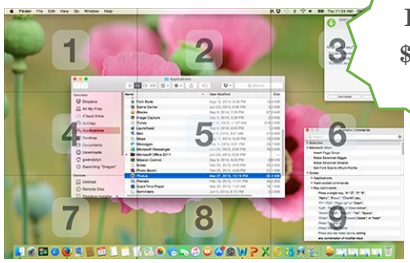
The Cirque SmartCat AG is a touchpad that you can plug into your computer. It also comes with a few extra buttons and is an easy solution if a touchpad works for you. It's also a bit cheaper than many of the other options.

Penclic Mouse

A Penclic mouse mixes the stylus from a tablet with a normal mouse. The pen grip is more ergonomic and can be used by both right and left-handers. It's a bit cheaper than the stylus and tablet option but it can be easy to accidentally press buttons on the pen when you try to grip it. It's available from Ergonomic Office in Australia.

Mousing by Voice

Dragon Naturally Speaking includes the ability to move your mouse around with your voice. You can either move the mouse a specific distance, e.g. "Mouse Up 1" with any number from 1 to 10. This only moves the mouse a few centimeters on the screen, though. You can also say "Move Mouse Down" and then "Faster or Slower" to change how quickly it's moving. Then say "Stop" when it's in the right spot. This is quite frustrating to do and very slow. There are more instructions for these modes by Googling 'Dragon mouse commands'.



You can also use Dragon's 'Mouse Grid'. In this mode, Dragon splits the screen into nine sections. You then choose a number and it will sub-divide that section into another nine sections that you can choose from, until the mouse is in the spot you want. You can then say "Click" or, if you want to drag it to somewhere else, you can say "Mark", then move the mouse to where you want to drag to and say "Drag". There are more instructions for this if you Google 'Dragon mouse grid'.

You can extend the functionality of the Dragon Mouse Grid by installing Caster. This makes the Dragon Mouse Grid faster and easier to use. You can find out more about it by watching the YouTube video Alternate Mouse Movement Modes at this link — https://youtu.be/UISjQBMmQ-I

Mousing by eye

You can even mouse using only your eyes and face. KinesicMouse uses your camera to completely control your mouse. It can even be used to play games. It requires a 3D camera, but that can come standard with many modern laptops. You can try it for two weeks for free if you want to try it or check if your camera will work with it. However, moving your eyes involves using your facial muscles so beware of "eye RSI" with this one!

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ACT RSI Newsletter, Spring 2017
Print Post Approved
PP 229219.00118

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