Could Methylation be considered a Cancer Screening Tool?

Upper Crossed Syndrome: Causes, Symptoms and Treatment

A Cup of Tea in the Consulting Room: Homoeopathic approaches to eczema and allergies

Vegetarianism and Sustainability

Adverse Events from Complementary Therapies
Cardiovascular Disease: The Critical Gaps in Current Management and the Central Role of the Natural Medicine Practitioner.

JUNE - JULY 2015

Cardiovascular disease (CVD) is the ultimate manifestation of the detrimental effects of a Western 'diet of plenty' and a sedentary lifestyle. Truly a modern epidemic, it shows no signs of abating despite the multitude of drugs and surgical options which have become broadly available. It has been said that you can’t medicate your way out of a problem you ate your way into, and this is why there is a tremendous opportunity for Practitioners of natural medicine to revolutionise the treatment of CVD. This seminar highlights the fundamental changes that have occurred in our understanding of the pathology and management of CVD, and the key role that you will play in the treatment of these patients in the future.

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A fter only two months in their role the new Board members have already done a lot of work. They have been active on your behalf, making some needed changes as well as being visible and responding to issues in our industry in the public arena.

**Out and about**

I went to Canberra to meet the education advisor Peter Emerton regarding education within our sector. It was a quick meeting, but he now knows who we are, and we have a voice and connection in Canberra.

Our relationships with Colleges continue to grow as we look into collaborations to increase services to our existing membership.

Thanks to Vice-President Stephen Eddey for attending the Training Packages Advisory Committee (TPAC) meeting on short notice in April. It is important that ATMS is an integral part of the communication about education in our modalities. This is particularly important when changes occur that may affect our members’ status.

Thanks also to Treasurer Antoinette Balnave, who spoke at the ACNT open day in Sydney. Antoinette encouraged many students to join up and displayed the true spirit of the Society. Thanks also to Vice-President Greg Morling, who attended the ACNT graduation ceremony and presented a graduation pack to the College’s outstanding student for the year.

The Endeavour Vitality day was attended by staff from the Meadowbank office along with Director Brad McEwen, who was there to answer questions about ATMS and help students become members. Endeavour College will be holding its graduation ceremonies at the end of May. ATMS has a prize for the Dux of the Perth campus and Brad McEwen will also be attending these and presenting this prize.

We are really excited as we are close to reaching the milestone of 10,000 likes on the ATMS Facebook page. Please jump onto Facebook and like the page to help us hit this significant milestone. ATMS has also been actively sharing updates on Facebook, which many members find a very useful resource as they can share updates on their pages without having to constantly create new content.

The release finally in March of the much leaked NHMRC report on homoeopathy resulted in a detailed response by ATMS, citing several flaws in the study. A major concern was that within the panel itself two out of three of the experts NHMRC consulted before publication expressed such significant concerns over the report’s methodology and selective use of data that they recommended it should not have reached the definitive conclusion that it did. Other significant issues with the report included the exclusion of an homoeopathic expert, the use of systematic reviews and the exclusion of both smaller studies and studies in languages other than English. In 2012 the Swiss Government undertook a detailed review of all of the research on homoeopathy and reached a very different conclusion, namely that it was both effective and cost-effective.

The Daily Telegraph featured a story about Chinese Slapping Therapy in early May in connection with the death of a diabetic seven-year-old. The article stated that the parents had been advised to take the child off his insulin while he was undergoing treatment. Thank you to Directors Daniel Zhang and Christine Pope for their prompt response to reporters on this issue. ATMS was quoted in the follow-up story and the article highlighted that this was not in any way part of the practice of Chinese Medicine or Acupuncture. Based on the ATMS
release the follow-up story advised that people should look for practitioners who were accredited by Associations. The practitioner mentioned in the article is not a member of ATMS, nor does it appear he is accredited by any other body. He has also been investigated in other countries for his practices. This story is a significant reminder that we should never take someone off medication unless we are working in conjunction with their doctor, particularly a medication such as insulin, where the consequences could be life-threatening.

**New Policies and guidelines**
I was really pleased that one of the first initiatives of the new Board was to introduce the audio-visual consultation policy and guideline for ingestive practitioners. In particular, thank you to Director Brad McEwen who drove this initiative by putting together a great policy document, which was further developed and endorsed in a very short period of time by our new enthusiastic Board. Other updated guidelines are being released, so please look out for them in Wise and Well and on the Website.

**Member survey**
The feedback from the members for the survey was overwhelming, with over 500 members completing the survey. We were pleased that so many members took time to provide detailed feedback.

The feedback totalled 297 pages and we will be publishing a summary in the journal.

**Education**
As many of you have heard, the qualifications of Advanced Diploma of Naturopathy, Advanced Diploma of Nutritional Medicine, Advanced Diploma of Western Herbal Medicine and Advanced Diploma of Homoeopathy will be removed from the Health Training Package in December 2015, with a teach-out period to December 2018. ATMS will continue to accept any graduates with these qualifications until the end of the teach-out period.

ATMS was asked to participate in the Degree Educational Standards Committee, a group of associations that are setting the benchmark for what should be taught at degree level for the qualifications above. The group is made up of the following associations: ANTA, NHAA, AROH, ARONAH and ANPA. At this stage the directors are still in discussion about joining this group, as we are fundamentally opposed to one of the conditions in the terms of reference. The Board is concerned with how this condition will affect existing members with older qualifications, so we have refrained from joining at this time. Communication lines are still open and we continue to foster a collaborative relationship with all associations that work for the Complementary Health Industry.

**Health Funds**
Because of the aforementioned changes and the uncertainty in the landscape of how health funds will react, I urge each of you to ensure that your membership does not lapse. We have had issues with members who have not renewed their membership and then, when they return after a one- to five-year break, cannot be accredited with a health fund. Continued membership ensures that you continue to have a provider number and your clients can claim health fund rebates. So if you decide to have a year off from practising and hold an older qualification, it will be very difficult for you to regain your accreditation status without further study.

ATMS was recently audited by Medibank and I am delighted to report that we are compliant.

**Save the Date**
The ATMS office and Board are in the process of planning the AGM, which will be held on the 31st of October in Melbourne. Look out for more details in your inbox through the Wise n Well.

**Final comment**
Trevor Le Breton was dismissed as CEO of ATMS at the end of April. However, as you have just read, the Board is ensuring the continued smooth running of ATMS until a replacement is found. Thank you to the Board members who have stepped up and represented ATMS. And thank you to the chairs of the various committees who have ensured the continued operations of those committees and supported me during this transition period. Also to Directors Robert Medhurst, Maggie Sands and Peter Berryman for answering members' queries via email. Special thanks go to Director Christine Pope who has assisted me in the office and kept the marketing side of ATMS ticking along. Also to Vice-President Greg Morling, who also has assisted in member queries and other office operations.

These are exciting times for the Society as we start a new chapter, I believe in what we do and who we represent and am happy to discuss any aspect with our members. So please do not hesitate to contact me through the ATMS office.

*Betty Tannous*
*President*
GSA would like to take the opportunity to thank the thousands of you that have taken out their professional insurance via the exclusive scheme we have designed for ATMS Members.

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atms@gsaib.com.au

A big thanks from the team at GSA
Upper crossed syndrome is a common postural dysfunctional pattern that describes the dysfunctional tone of the musculature of the shoulder girdle/cervicothoracic region of the body. This condition is given its name because an “X,” in other words a cross, can be drawn across the upper body (Figure 1). One arm of the cross indicates the muscles that are typically tight/overly facilitated and the other arm of the cross indicates the muscles that are typically weak/overly inhibited. The term rounded shoulders is often used to describe the rounded forward shoulder girdle and arm posture that is part of the upper crossed syndrome.

This condition is designated as the upper crossed syndrome because a similar postural dysfunctional pattern called the lower crossed syndrome is found across the pelvic girdle/lumbosacral region. Both the upper and lower crossed syndromes were initially described and named by a Czech physician and researcher named Vladimir Janda.

Causes
The primary cause of upper crossed syndrome is chronic postural stress to the upper body. Most tasks that we perform require us to work down and in front of ourselves, causing us to flex the upper spine, protract the head, protract the shoulder girdles, and medially rotate the arms. Examples include working at a keyboard, using a smart phone, reading a book in our lap, or tending to a baby (Figure 2). Maintaining this posture necessitates the contraction and shortening of certain muscles and the inhibition and lengthening of others (Table 1).

The muscles that are chronically contracted and shortened end up becoming overly facilitated and tight while the muscles that are chronically lengthened end up becoming inhibited and weaker. Ironically, even the lengthened weakened muscles can gradually become tight as they attempt to oppose the shortened facilitated muscles (and even the shortened tight muscles can become weak due to the altered length tension relationship). For this reason, upper crossed syndrome often results in opposing muscle groups that are described as locked short and locked long, neither of which are strong and efficient in their contraction capability.
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In addition to the pattern of muscle engagement created by a chronic rounded posture, some sources believe that there is a predisposition for certain muscles in the body to become overly facilitated and tight, and for others to become overly inhibited and weak. It is posited that flexors and medial rotators that are needed to achieve the primordial protective fetal position tend toward facilitation; and extensors and lateral rotators that open the body tend toward inhibition. Other sources state that larger, superficial muscles that function primarily to create movement tend toward facilitation, and deeper small muscles that function primarily to stabilize tend toward inhibition. While these divisions should not be taken as absolutes, these patterns do seem generally to be true.

In addition to entrenchment of the facilitation/inhibition pattern of musculature by the nervous system, once the upper crossed posture has been assumed for a long time, this posture is further entrenched by the formation of fascial adhesions in the tissues. In time, even the bones involved, primarily the vertebrae of the upper thoracic spine, will gradually deform based on the physical forces placed upon them; the increased flexion posture will cause the anterior vertebral bodies to compress, resulting in a wedge shape that only serves to further perpetuate the flexion posture.

**Signs and symptoms**
The first and most obvious sign of upper crossed syndrome is the characteristic postural dysfunction of protracted scapulae, medially rotated humeri, hyperkyphotic (overly flexed) upper thoracic spine, and a protracted/anteriorly held head, which is created by hypolordosis or even kyphosis (excessive flexion) of the lower cervical spine, hyperlordosis (excessive extension) of the upper cervical spine and head, and anterior translation of the head upon the atlas (Table 2).

**Table 2. COMPONENT POSTURAL DYSFUNCTIONS OF UPPER CROSSED SYNDROME**

<table>
<thead>
<tr>
<th>Hyperkyphosis of thoracic spine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypolordosis/kyphosis of lower cervical spine*</td>
</tr>
<tr>
<td>Hyperlordosis of upper cervical spine and head*</td>
</tr>
<tr>
<td>Anterior translation of the head*</td>
</tr>
<tr>
<td>Protraction of scapulae</td>
</tr>
<tr>
<td>Medial rotation of humeri</td>
</tr>
</tbody>
</table>

* Together, these components comprise protracted (anteriorly held) head.

Upon palpation, the following muscles will most likely be found to be shortened and tight: pectoralis major and minor, subscapularis, upper trapezius, levator scapulae, sternocleidomastoid (SCM), and the suboccipital group. The following muscles may be found to be lengthened and taut/tight: rhomboids, middle and lower trapezius, serratus anterior, longus colli and capitis, infraspinatus and teres minor, and thoracic paraspinals (erekctor spineae and transversospinalis).

The client will usually feel restriction of the following motions: retraction of the scapula, lateral rotation of the arm, extension of the upper thoracic spine, and retraction of the head. Efficiency of breathing will also become compromised because the postural collapse forward into thoracic flexion makes it more difficult to open the thoracic cavity and fill the lungs with air. This can be easily experienced. Assume the upper crossed syndrome posture and attempt to take in a deep breath.

Although pain is not necessarily a part of this condition, when this condition has existed for a long time, the client does often experience upper back and neck pain, both due to the tightness of the upper trapezius and levator scapulae, and due to the accompanying imbalanced posture of the head that places increased stress on all the posterior extensor musculature of the cervicothoracic region. If left unresolved for a long period of time, tension headaches also commonly accompany this condition.

**Assessment**
Assessment of upper crossed syndrome follows from the signs and symptoms of this condition. The most important assessment tool is static postural assessment, which will reveal the characteristic protracted scapulae, medially rotated humeri, hyperkyphotic upper thoracic spine, and an anterior head posture (hypolordotic lower cervical spine and a hyperlordotic upper cervical spine). Upon palpatory examination, tightness and the likely presence of myofascial trigger points (TrPs) will be found in the locked short muscles listed above. As stated earlier, tightness (and often TrPs) are also commonly found in the locked long muscles as well. And, due to the associated anterior head posture, it is also common for TrPs to be found in the other posterior extensor musculature of the neck and head. Verbal history will likely reveal chronic “rounded” posture of the upper body, often due to work or other habits.
Upper crossed syndrome is a dysfunctional postural condition of the musculoskeletal system, so no further medical diagnosis/assessment is needed. However, if X-Rays are done, not only will the altered posture of the cervico-cranio-thoracic spine be easily visualized on the lateral view, but the anterior wedging of the upper thoracic vertebral bodies will often also be visible in clients who have had this condition for many years.

**Differential assessment**
Assessment of upper crossed syndrome is straightforward and simple; therefore no differential assessment is necessary. If the client has the characteristic upper crossed posture, upper crossed syndrome can be assessed with confidence. However, this does not mean that the client does not have the presence of additional conditions that should be assessed. The presence of any musculoskeletal condition, especially such a pervasive postural dysfunctional pattern as upper crossed syndrome that affects the entire upper body, often necessitates compensation patterns that can then create other conditions.

**Manual treatment**
Given that upper crossed syndrome does not cause pain in the early stages, clients often do not present for treatment until with this condition is very chronic and progressed, and therefore stubborn and resistant to treatment. However, if consistent care is given, upper crossed syndrome responds very well to manual therapy. Moist heat, soft tissue manipulation, and stretching should all be done to the overly facilitated locked short musculature as well as the locked long musculature, with an emphasis on the locked short muscles. Even though it is always wise to begin with light to medium pressure, transitioning to deeper pressure soft tissue manipulation is often necessary to break up long-standing fascial adhesions. At the tendons, cross fiber work might be preferred. Once direct care to the musculature of upper crossed syndrome has been done, if time permits, it is wise to work the lumbopelvic hip joint complex region as well, given that interplay between upper crossed syndrome and lower crossed syndrome is likely.

For more stubborn cases, neural inhibition stretching techniques such as contract relax and agonist contract should be employed. Especially effective for the pectoralis musculature is to use pin and stretch technique. With the client supine and positioned toward the side of the table, pin the musculature with your finger pads as you bring the client’s abducted arm off the side of the table and down toward the floor into horizontal extension (Figure 3). Perform a number of repetitions of this procedure, each time changing the location of the pin pressure along the pectoralis musculature. To most effectively apply this technique to the pectoralis major, make sure that the client’s scapula is stabilized on the table; to most effectively apply this technique to the pectoralis minor, have the client move farther to the side so that their scapula is off the table and free to move.

Any chronic postural dysfunctional pattern will eventually result in the presence of fascial adhesions and/or fascial contraction in the ligament/joint capsule complex. For this reason, arthrofascial stretching (Grade IV joint mobilization) of the glenohumeral joint and the thoracic and cervical spinal joints is a necessary component of care and should also be done to address the intrinsic fascial tissue of the joints.

As effective as heat, soft tissue manipulation, and stretching can be for upper crossed syndrome, the application of only these treatment modalities can never fully and permanently resolve the condition. The objective of these therapies is to loosen the tight musculature and other taut soft tissues. However, that only addresses one half of the problem. The other half of each “arm of the cross” is the inhibited weakened musculature. To truly resolve upper crossed syndrome, these muscles must be strengthened. Therefore, referral to a fitness trainer, physical therapist, yoga or Pilates instructor, or the recommendation of specific exercises to strengthen the appropriate musculature is imperative (Box 1).

**Precautions/contraindications**
There are no specific precautions or contraindications when working on a client with upper crossed syndrome other than being careful to not be overly forceful with both soft tissue manipulation pressure and stretching when working with the client. It is important to be firm and assertive, but not aggressive.

**Self-care for the client**
When working with a client for the treatment of upper crossed syndrome, the importance of client self-care is critical. First, the client must be advised to avoid collapsing into the upper crossed rounded posture as much as possible. However, given the initial weakness of the shoulder girdle retractors and thoracic extenders with which they will present, it is important to explain to them that improving their posture will take time and patience. Therefore, they should not expect to suddenly sit and stand totally upright.
Rather, it will be a gradual transition from their present posture to “ideal” posture as the tight muscle groups are gradually loosened and the weak muscle groups are gradually strengthened.

A good postural habit to recommend from the beginning is to stand whenever possible with the hands clasped behind the back. This will passively increase shoulder girdle retraction and thoracic extension, without exhausting the still weak muscles of shoulder girdle retraction and thoracic extension. When standing in this posture, to minimize medial rotation of the arms, instruct the client how to pronate the forearms at the radioulnar joints instead of medially/internally rotating the arms at the glenohumeral joints (Figure 4). Next, be sure to discuss with the client all the scenarios in which they might be collapsing into the upper crossed posture. These might include sitting posture at a computer, driving a car, or most any activity in which the client works down and in front of the body.

It is also important to recommend moist heat followed by stretching of the pectoralis musculature and upper thoracic spine. When stretching the pectoralis musculature in a doorway, it is helpful to place the hand/forearm against the doorframe at various heights so that different aspects of the pectoralis musculature are preferentially stretched. Having the upper arm horizontal best stretches the sternocostal head of the pectoralis major; placing the hand/forearm lower preferentially stretches the clavicular head of the pectoralis major; and placing the hand/forearm higher preferentially stretches the pectoralis minor. Also, note that the foot that steps forward should be same-side foot as the side being stretched (Figure 5).

Figure 4. Standing with the hands clasped behind the back is a good default posture for clients with upper crossed syndrome. For the hands to be able to meet and clasp in back, the forearms should be pronated instead of medially rotating the arms. Art work Giovanni Rimasti.

Figure 5. Client self-care stretches for pectoralis musculature using a doorway with forearm/hand at differing heights. Reproduced with permission from Joseph E. Muscolino, The muscle and bone palpation manual, with trigger points, referral patterns, and stretching, 2ed., Elsevier, 2016.

Figure 6. Client self-care stretch for upper thoracic spine using an exercise ball. Reproduced with permission from Joseph E. Muscolino. Art work Giovanni Rimasti.

Stretching the thoracic spine across an exercise ball should be done with the feet stabilized on the floor or against a wall for balance (Figure 6). Using a larger ball at first creates a gentle stretch. Then transitioning to a smaller ball increases the stretch into extension. Recommend to the client to begin this stretch with repetitions of 5-10 seconds and gradually increase to holding the stretch for 30 seconds or more.

Finally, self-care exercises for strengthening are just as important as the moist heat and stretching component. Strengthening should be directed at the inhibited weaker musculature listed in Table 2. Following are the five primary objectives of the strengthening program: 1. Retraction exercises aimed at the rhomboids and middle and lower fibers of the trapezius; 2. Strengthening the serratus anterior as a protractor in place of the pectoralis...
musculature; 3. Strengthening the deep cervical flexors in place of the SCM and scalenes (this is often obtained by making sure that the chin is somewhat tucked when performing flexion); 4. Strengthening the lateral rotation musculature of the GH joint; and 5. Strengthening the thoracic extensor musculature.

Box 1 – Upper Crossed Syndrome and Pilates

Perhaps no other method of body conditioning is more beneficial for upper crossed syndrome than Pilates. The three main objectives of Pilates are strengthening of weak musculature, flexibility of tight/taut soft tissues, and proper neural control for healthy postural and movement patterns, precisely the movement therapy components needed for this condition.

Following are four excellent Pilates exercises for the client with upper crossed syndrome. The first two exercises are performed on a mat; the second two are performed on large Pilates apparatus (Ladder Barrel and Reformer respectively).

Mat exercises can be performed by the client at home. Large Pilates apparatus exercises would probably require the client to work at a Pilates studio in the presence of a qualified Pilates instructor.

Note: Caution is advised when recommending exercises; the client should gradually work up to the challenge of any exercise that is performed.
Adverse Events from Complementary Therapies:
An Update from the Natural Therapies Workforce Survey Part 1

Harris TA | Australian Institute of Applied Science, Stones Corner, Queensland
Grace S | Southern Cross University, Lismore, NSW
Eddey S | Health Schools Australia

Introduction
A range of complementary therapies are now commonly used to help reduce the incidence of chronic disease and generally improve health and wellbeing.1–3 With any form of treatment it is important to identify side effects and/or adverse events and demonstrate that the benefits of treatment outweigh the risks. Women of reproductive age are one of the largest groups of users of natural medicine. A critical review of 14 studies found that the prevalence of complementary medicine use by pregnant women ranged up to 87%.4 A longitudinal study of 11,454 women found that three out of four women used complementary medicine, with 50% of them using it on more than one occasion.5 This study reported a range of adverse events involving women diagnosed with polycystic ovarian syndrome using complementary medicine (including, naturopathy, chiropractic, acupuncture, massage, osteopathy, reflexology, homoeopathy and kinesiology). This study reported 37 adverse events to nutritional and herbal supplements, Traditional Chinese Medicine (TCM) and acupunture. Nine adverse events were to vitamins, seven to fish oil, six to TCM (two to acupuncture), two to herbal teas and five to vitamin supplements. The adverse events reported in this study included longer menstrual cycles, bowel habit changes, sleep disturbance and headaches.

Compared to conventional medicine there are relatively few recorded adverse events related to complementary and alternative medicine (CAM) and it is generally considered safe.6 In the treatment of cancer, for example, the reported adverse events of complementary therapies used alongside conventional therapies are relatively few. This includes ovarian cancer7 and cancer in paediatric populations.8 For the most part, complementary medicines are considered low risk. They are referred to as listed medicines in Australia. They are tested for quality and safety (if prepared by medical companies and sold commercially) but not for efficacy. Medicines considered high risk, or registered medicines, are tested for efficacy as well. The importation of medicines, particularly Ayurvedic and Traditional Chinese Medicines, for personal use is also a concern as it bypasses the safety and quality checks of the Therapeutic Goods Administration.9,10

Australia has a well-established ‘Blue Card’ scheme for reporting adverse events associated with all medicines and covers most health professionals.4 The public, practitioners and industry representatives are encouraged to report adverse events associated with medicines, vaccines and medical devices to the Therapeutic Goods Administration.9 Any adverse events involving actual or potential harm to a patient or caregiver should be notified. The Therapeutic Goods Administration relies on these reports to identify these safety issues. In 2011, the Auditor General’s Report highlighted a number of issues including failure to comply with regulatory requirements, lack of clarity about, and understanding of, regulatory requirements, and community concerns about labelling of complementary medicines.11

Safety concerns associated with complementary medicine have focussed particularly on medicinal plants and supplements, including their interactions with mainstream medicines. Hypericum perforatum (St Johns wort), for example, has been shown to reduce pharmaceutical effectiveness in a range of different drug classes.12–14 Table 1 illustrates well recognised adverse events and interactions of some complementary medicines. Evidence-based herb-drug interactions are now available in eMIMS. This resource has been designed to provide health professionals with access to information on clinically significant herb-drug interactions.15
### Table 1: Selected adverse events and interactions of complementary medicines

#### Selected adverse events of some complementary medicines (Therapeutic Goods Administration, 2005)

<table>
<thead>
<tr>
<th>Complementary medicine</th>
<th>Adverse event</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aristolochia species (not a permitted ingredient in Australia)</td>
<td>Renal failure</td>
</tr>
<tr>
<td>Bee products</td>
<td>Anaphylaxis</td>
</tr>
<tr>
<td>Black cohosh (Cimicifuga racemosa)</td>
<td>Liver impairment</td>
</tr>
<tr>
<td>Echinacea species</td>
<td>Allergic events</td>
</tr>
<tr>
<td>Guarana (Paullinia cupana)</td>
<td>Caffeine overdose</td>
</tr>
</tbody>
</table>

#### Selected interactions of some complementary medicines with pharmaceuticals (Blackmores, 2007)

<table>
<thead>
<tr>
<th>Complementary medicine</th>
<th>Interaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bilberry (Vaccinium myrtillus)</td>
<td>Warfarin, aspirin, antiplatelet drugs (increased risk of bleeding)</td>
</tr>
<tr>
<td>Ginkgo biloba</td>
<td>Warfarin (increased risk of bleeding)</td>
</tr>
<tr>
<td>Korean ginseng (Panax ginseng)</td>
<td>Digoxin (may affect digoxin assays), hypoglycaemic therapy (may affect blood glucose levels), phenelzine (may increase side-effects), warfarin (may decrease anticoagulant effect)</td>
</tr>
<tr>
<td>Red clover (Trifolium pratense)</td>
<td>Tamoxifen (conflicting evidence regarding effect on tamoxifen efficiency)</td>
</tr>
<tr>
<td>St John’s wort (Hypericum perforatum)</td>
<td>Warfarin, cyclosporin, oral contraceptives, protease inhibitors, reverse transcriptase inhibitors, simvastatin, verapamil, irinotecan, imatinib, methadone, tacrolimus, midazolam, omeprazole (may decrease efficacy); SSRIs (may cause serotonergic syndrome), tricyclic antidepressants (may decrease blood levels)</td>
</tr>
</tbody>
</table>

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1 Selective Serotonin Reuptake Inhibitors (SSRIs) are a class of antidepressants that acts by inhibiting the reabsorption of the neurotransmitter serotonin by presynaptic cells, therefore increasing the extracellular level of serotonin available to bind to the postsynaptic receptor.
Safety concerns about herb-drug interactions are well founded, given that most people who use CAM do so concurrently with Western medicine.\(^3\)\(^4\)\(^5\)\(^6\) Moreover, consumers of CAM tend to be reluctant to disclose their use of CAM to their medical practitioners. MacLennan (2006) found that 57% of clients did not tell their general medical practitioner about using CAM.\(^3\) Similarly, many practitioners failed to obtain a comprehensive medication history from clients before prescribing, thus exposing clients to potential risks associated with the combined use of prescribed medication and herbal or nutritional supplementation.\(^8\)\(^9\) Even if members of the medical profession were to take CAM histories they might have limited knowledge about CAM products and their potential interactions with prescription medicines. At one American teaching hospital 55% of residents could not name one herbal medicine and 69% were not aware of their carcinogenic potential.\(^7\) According to Smith et al.,\(^10\) more CAM practitioners than members of the medical profession are aware of potential interactions between complementary medicines and prescribed medications. However, it would be prudent for all practitioners to routinely ask clients about all current medications before prescribing further medication.

Adverse events are not confined to herbal medicines. They can be associated with any complementary therapy, including massage, kinesiology, and acupuncture, although the incidence of such events is difficult to ascertain. Adverse events following complementary medicine use, other than medicines, vaccines and medical devices, can be reported via the complaints mechanisms established by professional associations and for registered professions (Chinese medicine, chiropractic and osteopathy) via the Australian Health Practitioner Regulation Agency.\(^11\)\(^12\) Several studies have reported the incidence of adverse events associated with a range of complementary therapies.

One workforce survey reported on adverse events associated with the use of herbal medicine, nutritional medicine and homoeopathic medicine.\(^20\) The authors reported that a practitioner was likely to experience one serious adverse event every 11 months of full time practice, with 2.3 adverse events for every 1000 consultations in complementary medicine. A survey of TCM practitioners who practise Chinese herbal medicine and acupuncture found adverse event rates of one per 633 consultations.\(^7\) In another study, there were six adverse events for TCM out of 304 complementary medicine users.\(^8\) This study included self-reported adverse events by self-prescribing consumers with potentially poorly informed treatment choices, and may explain the higher rates of adverse events it reported. On the other hand, adverse events reported by TCM practitioners may be at risk of reporting bias.

Two further surveys were conducted by Hale et al. in 2002: one sought responses from remedial therapists\(^21\) and the other from acupuncturists, naturopaths and Western herbalists\(^22\). In the survey of remedial therapists\(^21\) 60.5% of respondents reported observing one adverse event in their practice lifetime. The most common events were skin reactions (34.4%) followed by headache/dizziness/nausea/digestive disturbance (31.2%) and muscular soreness (15.1%). Hales’ combined report on acupuncturists, naturopaths and western herbal medicine practitioners\(^22\) found that 37.9% reported occurrences of a range of adverse events, including sleepiness, insomnia, light-headedness and digestive conditions (e.g. stomach upsets, cramps, nausea, diarrhoea); 25% reported skin events; 5% reported flare-ups of symptoms; 2% reported muscle pains and 1% reported breathing difficulties and asthma.

The high prevalence of complementary medicine in our communities calls for ongoing investigation into its safety and efficacy. The purpose of this study was to provide an update on the type and nature of adverse events and their incidence in complementary medicine practice.

**Methodology**

The Australian Traditional Medicine Society Research Committee sought collaboration with all Australian professional associations to undertake a survey of the natural medicine workforce. Natural medicine professional associations were identified using information from previous surveys, online telephone directories (www.whitepages.com.au and www.yellowpages.com.au), and through the associations listed on the webpage www.naturaltherapies.com.au. Sixteen associations elected to participate in the survey (see JATMS 19(1): 13-18).

An email was sent by participating professional associations inviting members to take an online Qualtrics survey. A total of 14174 natural medicine practitioners were invited to participate. This survey contained three questions that related to adverse events. Participants were asked to record whether they had suspected that an adverse event related to treatment had occurred in the last 12 months and, if so to describe what type it had been. They were also asked to identify the modality involved. Data analysis comprised descriptive statistics. It was conducted by an independent statistician using Excel and SPSS. To enable correlations, primary disciplines were clustered into five main categories:

- Registered professions including medicine, osteopathy, chiropractic, acupuncture and Chinese medicine, podiatry and psychology
- Physical medicine including massage and bodywork therapies in all their forms (e.g. Swedish massage, remedial massage, aromatherapy massage, reflexology, kinesiology, Shiatsu, traditional Chinese massage, deep tissue massage therapy)
Ingestive medicine including Western herbal medicine, vitamins and minerals, nutritional supplements, aromatherapy products, and Ayurvedic and other traditional medicines

Energetic or vibrational medicine including Bach flower remedies, Australian bush flower remedies and homoeopathy

Mind-body medicine including cognitive behaviour therapy, counselling, hypnotherapy, meditation, guided imagery, hypnosis, biofeedback and spiritual healing

Results
A total of 3784 responses were received between 7 September 2012 and 8 January 2013. After blanks, duplicates, incomplete surveys, and surveys from participants not residing in Australia had been discounted 3177 responses (22.4%) remained for analysis. Due to missing data points, the total sample size varied for some questions.

Types of adverse reactions
The most prevalent adverse events reported in the previous 12 months for all complementary medicines were associated with the digestive system (36%), followed by the integumentary (26%), neurological (19%), and musculoskeletal systems (2%). The types of adverse events were classified as follows:

- Digestive reaction: adverse events included diarrhoea, nausea, digestive complaints, vomiting, gut event, gut pain, bloating, constipation, digestive discomfort and digestive upset
- Neurological reaction: adverse events included fainting, headache, dizziness, tiredness, light-headedness, panic attack, migraine, anxiety, nightmares and mild insomnia
- Pain reaction: pain, increased pain, pain in shoulder and arms and general soreness
- Skin reaction: mild skin event, bruising, rash with tiny pustules, skin itch, skin event, skin allergy and worsened eczema
- Unclassified: systemic infection and vague response

Frequency and severity of adverse event
Eight percent of respondents reported suspecting that an adverse event had occurred as a result of treatment. Ingestive medicine practitioners (19%) and registered professionals (13%) reported the highest incidence of suspected adverse events in their clients; mind-body medicine practitioners (5%) and physical medicine therapists (4%) suspected the least incidence.

Of the 215 cases of suspected adverse events reported, 21 (9.8%) needed to see a medical practitioner about them. Only six (2.8%) of those cases were reported to the Therapeutic Goods Administration (see Tables 2 and 3).

### Table 2: Need to see a medical practitioner about adverse event

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Not answered</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Energetic</td>
<td>4 (1.9%)</td>
<td>8 (3.7%)</td>
<td>1 (0.5%)</td>
<td>13 (6%)</td>
</tr>
<tr>
<td>Ingestive</td>
<td>8 (3.7%)</td>
<td>102 (47.4%)</td>
<td>5 (2.3%)</td>
<td>115 (53.3%)</td>
</tr>
<tr>
<td>Mind-Body</td>
<td>0 (0%)</td>
<td>2 (0.9%)</td>
<td>0 (0%)</td>
<td>2 (0.9%)</td>
</tr>
<tr>
<td>Physical</td>
<td>8 (3.7%)</td>
<td>51 (23.7%)</td>
<td>4 (1.9%)</td>
<td>63 (29.3%)</td>
</tr>
<tr>
<td>Registered</td>
<td>1 (0.5%)</td>
<td>20 (9.3%)</td>
<td>1 (0.5%)</td>
<td>22 (10.3%)</td>
</tr>
<tr>
<td>Profession</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>21 (9.8%)</td>
<td>183 (85.1%)</td>
<td>11 (5.1%)</td>
<td>215 (100%)</td>
</tr>
</tbody>
</table>

### Table 3: Reporting suspected adverse event to the Therapeutic Goods Administration

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Not answered</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Energetic</td>
<td>1 (0.5%)</td>
<td>7 (3.3%)</td>
<td>5 (2.3%)</td>
<td>13 (6%)</td>
</tr>
<tr>
<td>Ingestive</td>
<td>5 (2.3%)</td>
<td>38 (17.7%)</td>
<td>72 (33.5%)</td>
<td>115 (53.3%)</td>
</tr>
<tr>
<td>Mind-Body</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
<td>2 (0.9%)</td>
<td>2 (0.9%)</td>
</tr>
<tr>
<td>Physical</td>
<td>0 (0%)</td>
<td>5 (2.3%)</td>
<td>58 (27%)</td>
<td>63 (29.3%)</td>
</tr>
<tr>
<td>Registered</td>
<td>0 (0%)</td>
<td>3 (1.4%)</td>
<td>19 (8.8%)</td>
<td>22 (10.2%)</td>
</tr>
<tr>
<td>Profession</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>6 (2.8%)</td>
<td>53 (24.7%)</td>
<td>156 (72.6%)</td>
<td>215 (100%)</td>
</tr>
</tbody>
</table>

Adverse event by discipline
The disciplines involved in these adverse reactions are shown in Table 4. Of the total number of adverse events recorded in this study herbal medicine recorded the highest number, followed by manual therapies, nutritional therapies, acupuncture and homoeopathy.

In herbal medicine 65% of the adverse events were related to alterations in digestive function (e.g. vomiting, diarrhoea, constipation). Skin events also contributed to a high number of adverse events (23%) associated with herbal medicine, whereas neurological events accounted for only 10%. There were no reported instances of pain associated with the use of herbal medicine by participants.

In the manual therapies disciplines skin reactions (24%) were the most frequent adverse reactions, following by neurological reactions (22%), pain (18%) and musculoskeletal reactions (8%).
The number of adverse reactions associated with nutritional medicine was similar to that reported for herbal medicine, with digestive (58%) and skin reactions (21%) being the most numerous reported, followed by neurological reactions (16%). There were no reports of pain or any musculoskeletal reactions that were associated with the use of nutritional medicine.

Acupuncture practitioners reported very few adverse reactions. Fifty percent were neurological reactions, followed by skin (36%), pain (7%) and unclassified reactions (7%).

Homoeopathy practitioners also reported very few adverse reactions. Skin reactions were the most frequent (42%), followed by digestive (8%) and neurological (8%) reactions. Forty-two percent of the responses were unclassified, meaning that no obvious reason for the adverse event could be determined.

**Conclusion**

Only 8% of survey respondents reported an adverse event during the previous 12 months. Of those, the most frequently reported reactions were mild and short-lived. Most reported reactions were digestive (36%), integumentary (26%), and neurological (19%). From a discipline perspective, the most common adverse reactions were to ingestive medicine (19%), followed by registered professions (acupuncture and traditional Chinese medicine, chiropractic and osteopathy) (13%).

A full discussion of the results will be presented in Part 2 to be published in the Spring 2015 issue of JATMS.

**References**


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In recent times, the most studied epigenetic theory of cancer has been focused on DNA methylation. As researchers look for insights in cancer growth and proliferation, an increasing number of studies have recently been focused on DNA methylation changes. Simply put, some of the functions of methylation include gene regulation (turn on/off genes via SAMe); biotransformation (glutathione production); DNA base formation (from uracil to thiamine); mitochondrial support (adenosine as substrate for ATP; cell protection - NF-kB expression to reduce TNF cytotoxicity) and cell membrane formation (phosphatidylcholine and DHA to membrane). The process of methylation is made possible by the transfer of a methyl group (one carbon and three hydrogen ions) between compounds.

Although the process of methylation is relatively easy, it is clearly crucial for life and health because it plays an essential role in maintaining cellular function. Interestingly, the DNA methylation process occurs within the area of CpG dinucleotides. Even more interestingly, over 85% of CpG dinucleotides, which are spread out in the genome and are located in repetitive sequences, are generally hypermethylated/transcription silenced, and as such they maintain the integrity of the chromatin structure in the genome. The remaining 15% of CpG dinucleotides are clustered within the short DNA regions known as CpG islands. These islands are where 1% of the genome can be found. These sites are known to be hotspots for mutations.1

The methylation status of the genome is maintained by three methyltransferases (DNMT1, DNMT3a and DNMT3b) and by S-adenosyl-methionine donor. When there is a methylation defect, undermethylation (allows genes activation) or over-methylation (allows gene inactivation) of various regions of the genome may result in the suppression of tumour-suppressor genes or activation of tumour activating genes. The end-result of either hyper-methylation or undermethylation is the presence of an aberrant cell that is able to accelerate division without the ability to slow down the process. Hence, the aberrant cell mutation might not be necessarily associated with gene mutation, but with the changes in methylation patterns.2 Many types of cancer cells have been found to exhibit increased or reduced levels of CpG sequence methylation in promoter regions of genes whose protein products take part in the control of cell-cycle regulation. Disturbances in cell homeostasis may lead to neoplastic transformation.

With the knowledge that aberrant methylation helps to create a chaotic state from which cancer cells evolve, research has shown that hypomethylation may serve as a biological marker with prognostic values. In fact, aberrant methylation of DNA (global hypo-methylation accompanied by region-specific hyper-methylation) is frequently found in tumour cells. Global hypo-methylation, found almost universally in many human cancer tissue and cancer precursor cells, has been shown to reflect chromosome instability while hyper-methylation has been associated with the inaction of tumour suppressor genes.

Immunohistochemistry has shown that tumours with high levels of methylation are more likely to develop metastases and are associated with shorter survival in cancer patients.3 Immunohistochemistry has also shown that high levels of methylation are associated with greater cell proliferation and reduced apoptosis in cancer patients.4 This indicates that methylation changes in DNA play a role in the development and progression of cancer.

Could Methylation be considered a cancer screening tool?

Manuela Malaguti-Boyle | PhD cand., ND

Friso et al3 have recently demonstrated that peripheral blood mononuclear cell (PBMCs) DNA methylation status of individuals with cancer was ‘invariably decreased compared with control group subjects, indicating that cancer subjects have a systemically decreased global DNA methylation’. They also found that global DNA methylation in PBMCs was lower in the individuals who developed cancer during the eight years of follow-up compared to cancer-free controls. Additionally, it was observed that a decreased DNA methylation status was directly correlated with lower folate status and higher frequency of the MTHFR 677TT genotype. It is important to clarify that this genotype was shown to be associated with increased cancer risk only in those individuals who also recorded a low folate status. This finding...
confirms that methylation can be used as a screening tool for disease susceptibility, but it also highlights the interaction of diet, environment, epigenome, and genome in determining risk. On this note, a very interesting study conducted by Godderis et al reports that solvent exposure as well as polymorphisms in the glutathione S-transferase P gene were associated with global hypo-methylation. It has been proposed that solvent exposure leads to hypo-methylation because the methylation cycle and the glutathione synthesis pathway are closely linked. It follows that, in these circumstances, additional glutathione may be needed to support the main route of detoxification for many solvents, which have been shown to deplete other methyl donors, such as S-adenosylmethionine.

**Is methylation inheritable?**

Methylation is an epigenetic event that by definition is considered inheritable because it shows changes in the chromatin structure that is often accompanied by modified patterns of gene expression. For instance, many types of DNA damage such as oxidative lesions, alkalisation of bases or photodimers, have been shown to interfere with the ability of cell DNA to be methylated at CpG dinucleotides regions by DNA-methyltransferases (DNA-MTases). The resulting oxidative stress can interfere with the repair mechanism of alklation damage, increasing the level of potentially mutagenic lesions. On the basis of these findings, we now know that ROS production is directly associated with increased DNA damage and chromosomal degradation, causing alterations of both hyper-methylation and hypo-methylation. Therefore, it is correct to describe the process of carcinogenesis as one characterised by the expression of DNA-MTases activity with either hypomethylation or hyper-methylation or both of the progenitor tumour cell (target cell) DNA.

If unchecked the mammalian cell has enormous growth potential. A malignant cell with a doubling time of 24 hours can potentially form a mass of 1 kilogram in about 40 days. Although it is probable that many genes can suppress this growth potential, it is now understood that tumour suppressor genes are inhibited and inactivated by aberrant methylation in the CpG regions due to epigenetic events. Theoretically, the molecular mechanism by which the aberrant methylation of DNA takes place during tumour genesis points to two factors: a possible mistake of CpG region methylation in the new DNA strand and a missing ‘back-up’ of complementary methylated CpG in the parental strand.

The different classes of genes that are silenced by DNA methylation include tumour-suppressor genes and metastasis; DNA repair genes; genes for hormone receptors; and genes which inhibit angiogenesis.

Let’s take a closer look to some of these aberrant genes and specific cancers:

1. **The p16 tumour suppressor gene**

   Located at chromosome 9, a site that is particularly vulnerable because it frequently undergoes loss of heterozygosity in primary lung tumour. Research studies on lung carcinoma cell lines that did not express p16, found that about 48% showed signs of methylation of this gene. Furthermore, about 26% of primary non-small cell lung tumours showed methylation of p16. Primary tumours of the breast and colon displayed 31% and 40% methylation of p16 respectively.

2. **The CpG regions of E-cadherin (an adhesion molecule that suppresses tumour cell invasion)**

   Have been shown to be hyper-methylated in breast and prostate carcinoma cell lines that did not express this gene.

3. **Hyper-methylation of CpG regions in the oestrogen receptor**

   Has been shown in multiple tumour types. This finding is not completely unexpected given that the lack of oestrogen receptor expression appears to be a common feature of hormone unresponsiveness in breast cancers, even in the absence of gene mutation.

4. **Located at chromosome 3p24, a site that shows frequent loss of heterozygosity in breast cancer, lack of retinoic acid receptor-beta (RARbeta) gene has been reported for breast cancers. Using the methylation-sensitive PCR (MSP) assay, methylation of RARbeta has been found in 43% of primary colon carcinomas and in 50% of primary breast carcinomas.

Clinicians know that DNA methylation in the presence of the common C677T polymorphism can be modified by nutrients such as folate. The MTHFR C677T polymorphism leads to the amino acid alanine being replaced by valine. This variation has been suspected to induce hypomethylation and activate proto-oncogenes. According to recent research findings, this variation has been strongly linked to oral cancer.

It has been suggested that MTHFR C677T polymorphism involves the entire genome or specific CpG regions, affecting global methylation and thereby increasing the risk of cancer. Research has shown that individuals carrying the MTHFR C677T homozygous variant genotype have a decreased global DNA methylation, which may induce molecular modifications in the cell eventually leading towards the development of cancer.

**What types of tests are available?**

The large number of target genes related to cancer development that are silenced by aberrant DNA methylation suggests that inhibitors of this process may have interesting potential for cancer therapy. A variety of methods are used to evaluate the methylation status of genes. The most commonly used are Southern blot analysis; bisulfide genomic DNA sequencing; restriction enzyme-PCR, MSP; and the methylation-sensitive single nucleotide primer extension. Another suitable biomarker for determining the genomic methylation status of DNA is the peripheral blood mononuclear cells.
Although DNA methylation has been tested in blood as a circulating tumour cell DNA, more recently studies have focused on the possible role of circulating white blood cells DNA methylation in different types of cancer as a potential and easily obtainable marker to define the risk of malignancies in different tissue origins. In a study published in the Cancer Epidemiological Biomarkers & Prevention in 2013, researchers investigated the relationship between peripheral blood leukocytes DNA methylation and the risk of cancer. In a case-controlled study, leukocyte DNA hypo-methylation (PBMCs) was associated with an increased risk for adenoma with the subjects presenting a low blood folate. Further recent studies have confirmed that upon measurement, the peripheral blood leukocytes DNA methylation assay was lower in those individuals with bladder, stomach, breast and head and neck cancers. On the strength of ongoing research, many plausible theories have been formulated in regard to the usefulness of this test in the detection of tumours. Low status of PBMCs DNA could be caused by the fact that cancer develops from a certain organ which may alter the whole body metabolism that, in turn, mediates methyl-transfer events even for maintenance of a stable DNA methylation status. It is also possible that the global metabolic imbalance of DNA methylation status in cancer may cause a reduction in PBMCs DNA methylation in the blood. Furthermore, it is certainly possible that circulating cancer cells or cancer products such as miRNAs or other inflammatory mediators, may directly affect the PBMCs DNA methylation in blood, whilst the systemic condition that accelerates cancer development concurrently reduces DNA methylation in PBMCs. Interestingly, because global DNA methylation is an established predictor of increased cancer risk, it follows that lowered DNA methylation in PBMCs may also reflect the systemic condition prone to cancer development. This is a plausible conclusion given that it has been confirmed by research studies conducted specifically on the MTHFR677TT homozygous mutant genotype and low plasma folate in determining the highest risk of cancer.

**What type of nutrients could be used in practice?**

The discovery of polymorphic enzymes involved in critical steps of nucleic acids metabolic pathways has contributed to new insights in the interplay of genetics and nutrition for the phenotypic expression of a mutation. Several nutrients are involved in the maintenance of DNA metabolism, although the most compelling study indicates a critical role for folate, a nutrient involved in DNA synthesis/repair and DNA methylation. Reduced dietary intake or low-tissue levels of the sulphur amino acids methionine and cysteine have been associated with higher risk for developing malignancies due to their pivotal roles in methyl group metabolism and maintenance of redox status at cellular level. Preclinical and clinical studies suggest that part of the cancer-protective effects associated with several bioactive food components may relate to DNA methylation patterns. Folate consumption stimulates the metabolic pathway leading to the biosynthesis of homocysteine that is subsequently converted to its active form, tetrahydrofolate, a substrate for the enzyme MTHFR. The MTHFR C677T polymorphism also provides a paradigm of gene-nutrient interaction. The paradigm of gene-nutrient interaction in carcinogenesis. For example, this genotype is associated with a lower risk of developing colorectal cancer; however, the protective effect is observed only in individuals with an already adequate folate status, demonstrating that MTHFR C677T polymorphism may influences DNA methylation status through an interaction with folate status. In turn, MTHFR plays a central role in folate metabolism by irreversibly converting 5,10-methylenetetrahydrofolate to 5-methylenetetrahydrofolate, the active circulating form of folate. This end product provides methyl groups for methionine synthesis which in turn is required for the synthesis of SAMe, the primary methyl group donor. Dietary factors that are involved in one-carbon metabolism provide the most compelling data for the interaction of nutrients and DNA methylation because they influence the supply of methyl groups, and therefore the biochemical pathways of methylation processes. In addition to folate, other nutrients include vitamin B12, vitamin B6, methionine, and choline. Many nutrients have been found to protect against DNA damage and to maintain genomic stability. For example, vitamin E deficiencies are known to cause DNA oxidation and chromosome damage. Vitamin D exerts an antioxidant activity, stabilises chromosomal structure and prevents DNA double strand breaks. Magnesium is an essential cofactor in DNA metabolism and its role has been recognised in maintaining high fidelity in DNA transcription. A carotenoid-rich diet has been shown to reduce DNA damage. Vitamin B12 deficiency is associated with micronuclei formation. Zinc deficiency has been shown to reduce the utilisation of methyl groups from S-adenosyl-methionine resulting in DNA hypo-methylation. Dietary deficiency of selenium decreased genomic DNA, while Vitamin C deficiency has been associated with DNA hyper-methylation in lung cancer cells.

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A cup of tea in the consulting room:
The latest in homoeopathy about eczema and allergies.

Linda Beaver | DipHomMed
Linlee Jordan | MHLthSc BHom

Abstract
A collegial conversation between two Australian homoeopaths covers the management and treatment of some challenging cases of children with allergies and eczema, and reveals some of the most contemporary methods currently in use: using constitutional homoeopathic treatment with intercurrent aetiological remedies; anti-inflammatory remedies like Apis, Ars, Cham and Nux vom; and the work of homoeopath Jon Gamble on obstacles to cure.

The facts:
- Allergy and asthma account for an estimated 20% of Australia’s health expenditure and Australia has among the highest prevalence of allergic disorders in the developed world.
- Eczema in Australian children has increased from 3% to more than 20% in the past generation.

Linda (LB) and Linlee (LJ) settle down for a cup of green tea and a collegial chat about the management and treatment of some challenging cases of kids with allergies and eczema. A large part of their discussion is based on the work of homoeopath Jon Gamble and the concepts of obstacles to cure blocking the action of constitutional remedies.

**LB:** So Linlee, recently you used the term ‘google warriors’ in relation to the mothers of these kids. It has an exciting ring to it, can you tell me what that means?

**LJ:** That was my description of what a parent becomes after their child has been given a diagnosis of autism or something equally overwhelming. At first they are so busy trying to keep up with their visits to the paediatrician and juggle their lives with a sick child and work out how to correctly manage the allergy diet that they hardly have time to look after themselves. After the early phases of ‘Why me?’ and denial, anger and so on have been passed through they emerge with a determination to read everything they can. They become mini-experts on their child’s condition. Calling them warriors is a powerful acknowledgement of the effort they are putting into looking after their child.

**LB:** Expert, warrior and case manager as well.

**LJ:** Exactly.

**LB:** Another common scenario is the parents who have tried everything that conventional medicine has to offer, like the parents of Henry (pseudonym) in these photos (see Figure 1). Henry’s mum felt guilty - she saw her child suffering. She wondered if they were doing enough, and this drove her on to see one specialist after another. She felt singled out when well-meaning people in the street would make suggestions, as if she hadn’t already tried everything. Don’t you love this photo story Linlee? This is one happy family now.

**LJ:** Oh, he looks just like one of my little patients. Henry has the same look around his eyes, the same puffiness, redness and swelling. I’ve been giving my patient Apis 30c twice a week.
LB: What were the indications for Apis?

IJ: Well, his face is so puffy and he had been hospitalized twice with a bleeding colitis. I couldn’t help thinking his whole gut must be swollen and on fire as well. I gave Apis with the idea of calming his extreme response and calming down the lining of the gut. If the gut and mucous membranes are continually sensitive and inflamed, and in a similar condition to what can be seen on his face, then it makes sense to give the remedy regularly as a preventative. Apis is a sensible supportive remedy for allergic inflammation of the gut. Vermeulen describes tenderness, prickling, burning, soreness, swelling, and fullness in the gut as well as sensitiveness of the ileocaecal region. So tell me some more about the boy in the photos.

LB: Well, that’s Henry. He’s had eczema and allergies his whole life and been on constant medication. You can see how sad and listless he was in the ‘before’ photo. Henry became happy and energetic on a first prescription of Nat mur 30c. His mother said it was like having a new child. Even so, the eczema on his face came right back shortly after an initial strong improvement.

IJ: I used to hate that and puzzle about it and probably even change the remedy, but with these children with allergies I’ve almost come to expect it.

LB: We used to be so disappointed when the action of our remedies collapsed. Now we know to bring in the aetiological remedies to steady the progress. I do a timeline so that I can see the aetiologies at a glance (see Table 1).

IJ: I like the chart - it makes it very clear. When I look at the timeline I can see that he had a downturn in his health at seven months and then at twelve months - there’s a cluster of new symptoms.

LB: I gave Infanrix hexa 30c first as it’s a standout for eczema (Infanrix hexa is the homoeopathic remedy made from the vaccine in Australia, which includes Diphtheria, Tetanus, Pertussis, Hepatitis B, Polio, Hib.)

IJ: Go on.
The action of the constitutional remedy is undermined by these other factors that need to be incorporated into the treatment. In complex cases my general plan is to give constitutional treatment with intercurrent aetiological remedies. Henry’s main remedies have been: Nat mur 30c and 200c and Ign 30c. Infanrix hexa 30c, MMR 30c, and Antibiotic mix 30c, all given as intercurrents in that order. When there is a short detox event, I change it up and give Sulph 30c instead of Nat mur/Ign. I start simply with one or two remedies but after a while a typical prescription might look like this:

Nat mur 200c twice a week
Infanrix hexa 30c twice a week
Ign 30c twice a week.

Later I gave Arn 30c, Sulph 200c and MMR 200c. The detox for vaccines is more gentle when given in alternation with the constitutional remedy. The improvement you see in the photos took place over five months, so fairly quickly, which is what you want. In the most severe cases of eczema you can see a skinny, underweight child who has a compromised immune system and frequent infections. Henry’s condition worsened over winter, with a return of puffiness and swelling about the eyes during a bout of gastro. Ars 30c was given, which settled both the gastro and the inflammation. Since then, Ars has been the most appropriate anti-inflammatory remedy for Henry.

Anti-inflammatory remedies like Apis, Ars, Cham and Nux vom are needed to help with the most distressing symptoms of allergies and food intolerances. Parents can give them twice a week and also it’s good to tell parents to give an extra dose, for example before going to a party. This is a major part of the treatment for complicated atopic cases where I try to work out a therapeutic remedy and give it once or twice a week as a preventative. These children may not have been as successfully treated years ago by us but we now have so many methods to choose from.

We can do a hair tissue mineral analysis to check for heavy metals or mineral deficiencies since we know that heavy metals can block the action of homoeopathics. Especially those cases that respond well to every remedy at first without any real improvement in the long-term, as well as those cases that worsen with every remedy without any improvement.

I have a good example of that. I have given a six-year-old wild child with eczema and allergies Tub bov, Hyos, Stram, Dulc, Sacch, etc. He does well on each of the remedies but instead of the two steps forward and one step backwards which we expect, he does one step forward and one step backward. Finally a hair analysis was ordered and it showed lead in the toxic range - off the top of the chart. His symptoms don’t easily point to Plumbum and no practitioner had ever thought to prescribe it even though his dad is a builder and his mum helped to renovate the bathroom while she was pregnant with him.

We’ve been talking about causations such as antibiotics, vaccines, inflammation and heavy metals but what about the emotional side? Anger comes to mind. Passion is the positive side of anger. I had a case of allergy that responded well to Arg met, a remedy that is indicated when the emotions are not displayed. This person never showed her anger or wanted the passion of an intimate relationship. She had recurrent allergic urinary symptoms similar to, but not, a UTI.

That theme fits with Nat mur, the remedy you gave Henry.

<table>
<thead>
<tr>
<th>Table 1 Aetiology Timeline</th>
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<tbody>
<tr>
<td>Age</td>
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<tr>
<td>---</td>
</tr>
<tr>
<td>Pregnancy</td>
</tr>
<tr>
<td>Birth</td>
</tr>
<tr>
<td>2 weeks</td>
</tr>
<tr>
<td>3 weeks</td>
</tr>
<tr>
<td>2, 4, and 6 months</td>
</tr>
<tr>
<td>7 months</td>
</tr>
<tr>
<td>12 months</td>
</tr>
<tr>
<td>18 months</td>
</tr>
<tr>
<td>21 months</td>
</tr>
<tr>
<td>2 years</td>
</tr>
</tbody>
</table>

Recurrent vomiting, not previously mentioned (as happens so often - his parents had forgotten about it) also stopped after Ars. Morgan-pure resulted in a much appreciated growth spurt, and Psorinum 30c was given as a follow-on to Sulphur when the eczema was worse in the winter.
The information and photographs in this article have been published with the consent of the patients’ parents.

**References**


* Neocate is an amino acid-based infant formula designed for babies with a cows’ milk allergy or multiple food protein allergies.
The Use of ENAR Therapy in Australia –
A Phase IV Post-Market Surveillance Study

Rod Bonello | BSc, DO, DC, MHA, FACC, FICC

Abstract

Objective: To report the effectiveness and safety of the ENAR device as well as the conditions for which the therapy was employed and its perceived effectiveness. The impact of therapy on medication use is also explored.

Design and setting: An Australian post-market, web-based survey of ENAR therapy users.

Results: Most respondents (76%) used ENAR exclusively for pain relief for musculoskeletal disorders, especially back, shoulder and neck pain; 8% used ENAR exclusively for non-musculoskeletal disorders; while 16% used ENAR for both. Respondents reported a mean reduction in pain of 70% [t(423) = 38.73, p< .001] and functional improvement of 62% [t(423) = 10.45, p< .001] using 11-point numerical rating scales. Following ENAR treatment medication reduction was reported by 91% of respondents. Very few respondents reported safety incidents or concerns with the therapy.

Conclusions: Most respondents reported high satisfaction and a reduction in medication use following ENAR therapy, with between 15-20% reporting complete pain relief. The self-delivery of ENAR may, in part, account for the high level of satisfaction.

Introduction

The electro neuroadaptive regulator (ENAR) device has been available on the Australian market for over 10 years. It is an approved product registered with the Australian Therapeutic Goods Administration (Listing ARTG 147761) in the product category Medical Device Class IIa along with devices such as transcutaneous electric nerve stimulators (TENS).

ENAR therapy is not well researched, however two studies have been conducted in Australia.1,2 The first involved a randomised controlled trial on the use of ENAR therapy for chronic neck pain sufferers and showed superior efficacy for ENAR over both TENS and sham treatment alternatives. The second study was a post-market surveillance survey in which ENAR users reported their experiences on efficacy and safety of the therapy. This paper reports aspects of the second study.

While initially developed for pain relief, the ENAR device has increasingly been adopted for other purposes. These are wide-ranging with patients and therapists both reporting that the device has assisted in conditions sometimes unrelated to pain such as neurological disorders, skin disorders and so on. These reports were the stimulus to conduct the second study.

The aims of this paper are:

• to report on a survey of patients on their experiences of using the ENAR device
• to examine the range of applications to which the device is put
• to ascertain the level of efficacy for those applications by patient reports
• to review safety issues related to the use of ENAR therapy
Methods
A post-market survey model was employed where each person on the device distributor’s database was contacted and asked to participate in the survey. The database contained contact details of each person who had purchased an ENAR device from the distributor or had otherwise enquired about the device. A novel 33 question survey was created seeking basic demographic information and questions surrounding the conditions for which the device was applied including the use, effectiveness and safety of the device. The protocol was reviewed by the RMIT University Human Research Ethics Committee and granted approval.

Findings
Respondent number, age, condition chronicity and gender
Total participant number was 481 of which 442 answered almost all questions. The respondents were aged between 18 and 88 years (mean 54 years, sd 14 years). The most common age among participants was 56 years. One respondent answered on his/her experiences using the ENAR on their child. Respondents generally had a chronic history of the conditions for which they used the ENAR device - chronicity averaging 6.4 years. Females comprised 69% of the respondent pool. Women are well known to be more enthusiastic consumers of health care services, including CAM services. The age and gender profile in this sample was generally consistent with the results from a 2007 Australian survey on CAM use except for our respondents being in an older age bracket.

ENAR use
Respondents were asked to report the primary problem for which they used ENAR. The three most common responses (in order) were back pain, shoulder pain and neck pain. Many respondents cited more than one problem in response to this question. Musculoskeletal complaints were identified as the primary problem by 405 (91.6%) respondents, and 106 (24%) for non-musculoskeletal conditions. An overlap of 69 respondents (16%) was noted where respondents used ENAR for both. Thirty seven respondents (6%) had a non-musculoskeletal problem as their sole ‘primary’ complaint.

Responses were also analysed as to the pain component of the problems. Conditions with pain as their main symptom or feature were categorised as ‘Painful syndromes’ and those with a primary symptom other than pain were categorised as ‘Non-painful syndromes’. By this analysis, 88% of respondents reported a painful syndrome as their primary problem for the use of ENAR. Table 1 lists the conditions for which ENAR was used.

Number and duration of ENAR treatments
Participants were asked about the number of ENAR treatments they had, and the typical duration of each treatment. A bipolar distribution of responses was noted with the two most likely responses describing either a short term treatment protocol (1-4 sessions) or, alternately a more lengthy regimen of therapy (20+ sessions). Making estimations for each of the responses yields a total number of treatments of about 5,500 for the cohort at an average of 25 treatments per respondent.

With respect to the duration over which therapy was rendered, most respondents (55%) reported that treatment was received over a period of months rather than days or weeks. The average reported duration of therapy across the whole sample was 172 days = 5.6 months. It is noted that a large percentage of respondents were home users who had self-administered the therapy.

Changes in pain level associated with ENAR therapy
A Numerical Rating Scale (NRS) was employed to record pain levels before and after treatment. Respondents were asked to select the number along the scale which corresponded to their pain level. The level of pain was asked both prior to ENAR treatment and following ENAR treatment. A change in NRS of at

<table>
<thead>
<tr>
<th>Region or system involved</th>
<th>Count</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Back*</td>
<td>111</td>
<td>25</td>
</tr>
<tr>
<td>Shoulder*</td>
<td>60</td>
<td>14</td>
</tr>
<tr>
<td>Neck*</td>
<td>56</td>
<td>13</td>
</tr>
<tr>
<td>Knee*</td>
<td>42</td>
<td>10</td>
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<tr>
<td>Neurological</td>
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<td>7</td>
</tr>
<tr>
<td>Ankle/Foot*</td>
<td>27</td>
<td>6</td>
</tr>
<tr>
<td>Arthritis*</td>
<td>25</td>
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</tr>
<tr>
<td>Fibromyalgia*</td>
<td>25</td>
<td>6</td>
</tr>
<tr>
<td>Hip*</td>
<td>22</td>
<td>5</td>
</tr>
<tr>
<td>Headache</td>
<td>16</td>
<td>4</td>
</tr>
<tr>
<td>Wrist/Hand*</td>
<td>14</td>
<td>3</td>
</tr>
<tr>
<td>Thoracic spine*</td>
<td>14</td>
<td>3</td>
</tr>
<tr>
<td>Digestive</td>
<td>13</td>
<td>3</td>
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<tr>
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<td>3</td>
</tr>
<tr>
<td>Emotional</td>
<td>9</td>
<td>2</td>
</tr>
<tr>
<td>Elbow*</td>
<td>9</td>
<td>2</td>
</tr>
<tr>
<td>Skin</td>
<td>8</td>
<td>2</td>
</tr>
<tr>
<td>Hormonal</td>
<td>6</td>
<td>1</td>
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<tr>
<td>Cardiovascular</td>
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<tr>
<td>Genito-Urinary</td>
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<td>1</td>
</tr>
<tr>
<td>General health</td>
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<tr>
<td>Musculoskeletal syndrome (MSK)*</td>
<td>336</td>
<td>76</td>
</tr>
<tr>
<td>Non- Musculoskeletal syndrome</td>
<td>37</td>
<td>8</td>
</tr>
<tr>
<td>Had both MSK and Non-MSK syndrome</td>
<td>69</td>
<td>16</td>
</tr>
<tr>
<td>Painful syndrome</td>
<td>387</td>
<td>88</td>
</tr>
<tr>
<td>Non-painful syndrome</td>
<td>55</td>
<td>12</td>
</tr>
</tbody>
</table>

Notes: A number of respondents cited more than one problem as the reason they commenced ENAR therapy. Musculoskeletal conditions are shown by *
least 1.3 scale points has been reported to represent a clinically significant difference which is meaningfully beneficial from the patient’s perspective. Commonly a change of at least 2.0 NRS points is a therapeutic goal.

Prior to ENAR treatment respondents had an average pain level of 7.16 NRS points. Following ENAR therapy pain levels were reported to average 2.04. This equates to a fall of 5.12 NRS points, or a greater than a 70% reduction in pain. A paired-samples t-test was used to determine statistical significance for this finding. The results show a strong and significant reduction in pain ratings, t(423) = 38.73, p< .001.

Figures 1 and 2 show NRS pain responses before and after ENAR therapy. As numbers approaching ten represent high levels of pain and numbers closer to zero represent lower levels of pain, the shift towards to left in the two graphics represents a diminution of pain responses after ENAR treatment.

Changes in function or activity associated with ENAR therapy
A Numerical Rating Scale (NRS) was also employed to record level of function or activity before and after treatment. A change of at least 2.0 Functional NRS points is regarded as a clinically significant therapeutic goal. Prior to ENAR treatment respondents had an average functional activity level of 3.49 NRS points. Following ENAR therapy functional activity levels were reported to average 5.65. This equates to an increase of 2.16 NRS points, or an increase in functional capacity of 62% in their specified activity. Again, a paired-samples t-test was used to determine statistical significance for this finding. The results show a strong and significant increase in functional activity NRS, t(423) = 10.45, p< .001.

About 35% of respondents reported that the effects of ENAR treatment with respect to functional improvement lasted for some days. Almost as many (33%) found that the effects lasted for months. Once again a substantial proportion (23%) reported a treatment effect which lasted years, despite this being a population of chronic sufferers.

Relationship between length of time of primary problem (chronicity) and pain or activity changes
Chronicity is a major factor affecting treatment effectiveness for many types of therapy. For this reason an analysis was undertaken to ascertain whether the effectiveness of ENAR in terms of pain reduction or activity improvement was related to the chronicity of the patient’s problem. A non-parametric correlation was performed. There was no significant relationship between length of time and pain reduction, r = -.07, p = .08, but there was a significant positive correlation between length of primary problem and improvement in activity, r = .10, p = .009. Participants who reported problems with higher chronicity also reported larger improvements in activity levels. This is an encouraging finding for those who have long-standing problems, which are associated with a decline in ability to carry out certain movements or functions.

Effects of ENAR therapy on medication use
The impact of ENAR therapy on use of medications was also investigated. About half of the respondents were taking medication prior to commencing ENAR therapy for their primary problem. Of these, 91% reported that because of ENAR treatment they were able to reduce or eliminate their medication use for the management of their primary problem. In this group 42% stated that they were able to cease medication altogether for their primary problem. Only one respondent of the 206 who reported that they changed their medication use following ENAR treatment said that he/she increased medication use after ENAR treatment. These results are depicted in Figure 3.

In examining the impact and value of any new or alternate therapy an important consideration is the ability for patients who use that therapy to become less reliant on other forms
of treatment. This is especially so in terms of medication use. Any therapy which leads to reduced levels of medication is potentially attractive. In the area of pain relief, medications such as non-steroidal anti-inflammatory drugs are a common source of serious harmful side-effects. In addition, prescription drugs, which are heavily subsidised are a major drain on the National health care budget. ENAR treatment appears to offer an alternative to drug therapy in many cases, especially for painful, musculoskeletal problems.

Perceptions of end-users on the overall effectiveness of ENAR therapy
Participants were asked to rate the overall effectiveness of ENAR therapy on their primary problem. Respondents report...
ENAR to be a highly successful therapy. ENAR was reported by almost all respondents (98%) to have a positive effect on their primary problem. Almost two thirds reported ‘great effectiveness’ and almost one in five said that ENAR ‘cured’ their problem.

**Respondent perceptions of comparative effectiveness**

Respondents were asked to rate the effectiveness of ENAR compared to other therapies that they had tried previously. On a five point scale ranging from ‘Much worse’ to ‘Much better’, 75% of respondents rated ENAR as much better. In total almost 93% rated ENAR as either ‘Better’ or ‘Much better’. Less than 2% rated ENAR as either ‘Worse’ or ‘Much worse’ than alternative therapies they had tried.

**Adverse effects in using ENAR**

All therapies which are effective carry with them a degree of harm or adverse outcome. A therapy is desirable if its efficacy profile is at least as good as alternative therapies and if its adverse effects are minimal or at least acceptable in the context of clinical decision-making.

Seven percent of respondents (30) reported a negative or adverse event. Respondents were asked to specify details of their response. On review of individual response descriptions most are relatively trivial and related episodes of subsequent short-term discomfort. Mild electric shock was noted, as was aggravation of the condition if the therapy was excessively applied. It is recommended that practitioners and home users be advised that excessive use of the ENAR device may cause a mild adverse event. Further, that under such circumstances one could expect to experience short-term muscle soreness, nausea, headache or tiredness. Considering the high levels of effectiveness reported by participants, the low frequency of reported adverse effect, and the minor nature of those effects, ENAR can be regarded as a safe treatment.

**Limitations to this study**

As this was a retrospective study, recall bias is an inherent weakness. Another limitation is regression to the mean. The natural history of most health care complaints is that they tend to get better over time and individuals who try a therapy are most likely to do so when their condition is at its worse. As the severity of most conditions fluctuates over time, it is to be expected that people undergoing treatment are likely to improve over time. For this reason, the results of the comparisons between therapies in this report are probably more valid than the results reported for the therapy itself. As both accounts were favourable towards ENAR, this difference may be moot. This study did not have a placebo control group. Because of this it is not possible to measure the magnitude of efficacy of ENAR therapy. Therefore, the conclusions presented here are conservative.

**Conclusions**

Post-market survey respondents reported high levels of effectiveness of ENAR and low frequency of adverse effects which were of minor nature. The main conditions for which ENAR is used are painful musculoskeletal complaints, although a wide range of other types of problems were reported to have been successfully managed with ENAR. Most respondents reported that they had decreased their use of medication following ENAR therapy. Further prospective, controlled trials should be conducted to better understand the potential of ENAR as an emerging therapy.

A feature of ENAR is its facility to be self-used, not practitioner dependent. In terms of health care sociology, this is in keeping with attitudes which embrace higher levels of personal control or empowerment over one’s health. This may have contributed to the high level of satisfaction with ENAR.

**Acknowledgement of funding**

The post-market survey and reporting were funded jointly between the sponsor Enlightened Therapies Pty Ltd and the Australian Government via an Enterprise Connect Researchers in Business grant in 2013.

**Competing Interest**

None.

**References**


It is well documented that stress aggravates a wide range of pre-existing conditions such as skin disorders, headaches, pain, insomnia and anxiety. Every patient who visits a natural therapist experiences some kind of stress; often long-term, chronic stress. Chronic stress increases physical and cognitive impairment and decreases immune function.

Relaxation therapy is evidence-based, efficacious, non-invasive and cost-efficient. It can maintain health and well-being amid the rapid change and chronic stress of today’s society. In natural therapy practice, teaching patients how to relax can enhance physical, emotional and cognitive function and enhance the ability to cope with daily life.

Relaxation training improved sleep quality and cognitive function in people aged 60 years or older and anxiety was reduced by relaxation techniques in hospitalised patients with cancer. Depression was reduced in caregivers, in women with breast cancer, people with chronic fatigue, post-traumatic stress disorder and adolescent psychiatric patients. Relaxation reduced nightmares, depression, sleep disturbances and dissociation in trauma-exposed individuals and improved postsurgical wound healing.

Deep, diaphragmatic breathing can reduce pain intensity and pain perception. Very few people regularly breathe deeply and slowly, yet it is simple to teach and easy to learn. Guided imagery involves mental images, sounds or feeling for therapeutic purposes and can reduce effects of psychological distress, disease, disability and pain. Guided imagery can reduce pain, fatigue, depressed mood and anxiety.

Massage therapy encompasses a wide range of hands-on techniques, from gentle holding to deep tissue techniques. There is evidence that massage can enhance immune function in healthy people and those with cancer. Massage can enhance quality of life in people with brain tumour and decrease anxiety and depression in people with fibromyalgia.

Natural therapists can implement relaxation techniques into practice to enrich clinical outcomes. Assisting a client to relax does not have to be time-consuming and success depends on only two things. First, natural therapists need to teach relaxation techniques accurately. Secondly, clients are required to practise regularly. Relaxation is a practical skill that needs to be performed regularly to be effective.

Learning, experiencing and teaching relaxation therapy is an innovative, evidence-based way to improve both physiological and psychological conditions. It is an efficacious tool for natural therapists to include in their ever-expanding treatment options.

For references, please contact the Editor at atms.journal@westnet.com.au

Judy Lovas researched the effects of massage therapy on immune responses and the effects of relaxation therapy on secondary conditions of people with spinal cord injury. Since then, Judy has combined clinical practice with research and teaching. She also teaches psychology at the Australian Catholic University. Judy’s work focusses on relationships between psychological and physical health based on Psychoneuroimmunology (PNI). PNI examines interactions between the CNS, endocrine and immune systems and provides evidence for the impact of stress and relaxation on both the mind and body. Judy conducts accredited three hour seminars in evidence-based benefits of relaxation therapy. Her dynamic presentations offer effective skills for conditions such as pain, fatigue, insomnia, anxiety and depression. Judy’s seminar enhances patients’ health and practitioners’ well-being.
Vegetarianism and sustainability

Alexis Clarke

Alexis has graduate and post-graduate qualifications in Journalism and Graphic Design. She recently completed a Graduate Certificate in Sustainability at the University of Sydney.

This paper focuses on meat as a distinct product category. It does not consider seafood or dairy.

Background

Worldwide meat consumption has doubled in the last 50 years and experts predict that by 2050 twice as much meat will be produced for consumption as is today, for a projected total of 465 million tons. For more than a decade the largest increases in production have taken place in developing countries: more than half the world’s total meat production took place there over this period. Despite this, more than one in seven people globally do not receive sufficient protein and energy from their diet, and one in every three people worldwide (encompassing all age groups and populations) suffers from malnutrition. An increase in global population and the relative declining per capita availability of energy resources, land and water have contributed to this. Technological advances in agriculture have secured increased production and output but have meant devastating environmental impacts, including climate change. The complexities of competing agendas of food production and environmental sustainability will have to be carefully managed: “Balancing competing demands from the need to sustainably intensify food production to meet growing demands for food while also responding to consumer demands for more meat and more dairy products will be a significant challenge for food systems in the coming decades.”

Current Consumption

On average each person in the world consumes approximately 40kg of meat per year. This is expected to increase to 45.3kg by 2030. Predictions for meat consumption differ between developing and developed countries: 36.7kg and 100.1kg of meat per person respectively. In 2011, Australians consumed around 111kg of meat per person: 33kg of beef, 9kg of lamb, 43kg of chicken and 25kg of pork. Currently Australian consumers allocate about 40% of their total food expenditure to meat.

In developing countries, access to meat of any variety means increased food security and decreased malnutrition. In poorer countries the less affluent are forced to buy whatever is affordable and readily available, whether it be poor...
quality fruit and vegetables, processed foods or factory-farmed meat and dairy.

“The perception of the role of meat, particularly red meat, in the global diet is dichotomous”. Should the first priority be adequate food security and nutrition standards for all, or should environmental conservation come first? This paper presents some of the key arguments in this complex debate.

Food security and national standards
How important is meat in human diets?
A dichotomy exists regarding attitudes to meat consumption: meat is deemed both a protein-rich and nutrient-packed dietary necessity and an artery-clogging, life-shortening food that should be avoided at all costs. On the one hand red meat contributes key micronutrients (iron, vitamin A, vitamin B, essential fatty acids and zinc) and protein to the global food supply, all of which are essential for human health”. But, on the other, excessive consumption of meat in developed countries is often linked with non-communicable diseases, obesity and cancer. And as Australians we are disproportionately guilty of excessive consumption. A report released by the Australian Institute of Health and Welfare showed that Australians consume 116kg of meat per year, compared to the world average of 40kg.

Recommendations to reduce consumption of animal fat, and in particular saturated fat, continue to dominate dietary guidelines, with emphasis on selecting lean cuts of meat and trimming external fat. Studies have shown that lean meats such as chicken and beef can contribute to a well-balanced, energy-restricted diet to support weight loss or maintenance.

Can we live without meat?
It is entirely possible for vegetarians to meet all their nutritional needs without having to consume meat. Vegetarian diets, when properly planned, provide the full range of protein, essential fatty acids, vitamins, minerals and fibre necessary for optimal nutritional status. However dietary planning needs to take into account that nutritional needs may increase during stages of growth and development, pregnancy and lactation, which may mean that it becomes necessary to eat meat at certain stages of life.
Malnutrition in the developing world

In developing countries it is estimated that 16-28% of the population are consuming insufficient energy-rich foods, compared to less than 5% in developed countries. On average, only 10% of this limited energy intake is consumed as protein, with less than 25% derived from high-quality animal protein. The Food and Agriculture Organisation of the United Nations (FAO) predicts that by 2050 consumption of red meat worldwide (bovine and ovine) will increase by approximately 200%, and that of pork by 158%. Predicted growth in production and consumption of livestock products suggests an opportunity for increased food security among a growing population. The FAO notes that livestock varieties, such as cattle, that consume primarily roughage and agro-industrial waste products, add to the food supply beyond what can be provided by crops. Feeding agri-waste to livestock raised for food contributes more to the food supply than would be contributed by people eating crops and grains because the total of the end product of cattle-raising is more nutritious than the content of the vegetable matter the cattle consumed.

The effects of malnutrition on child survival in developing countries are devastating. It has been noted that protein malnutrition is a causal factor in 49% of the approximately 10.4 million annual deaths of children under five years of age. UNICEF have also estimated that one-third of children under the age of five in the developing world have stunted growth. Stunting is caused by long-term insufficient nutrient intake and frequent infections. On top of this, iron deficiency and anaemia affect nearly 600 million pre-school and school-aged children in developing countries. A recent study highlighted how important meat is to the diets of children in developing countries to decrease stunting and increase the sufficiency of key micronutrients. Meat is also important to the diets of pregnant and lactating women: “Efforts to reduce micronutrient deficiency through the increased availability of animal proteins are also important to support maternal health”.

Environmental Conservation

Changes to global patterns of wealth and prosperity are changing rates of food production and consumption and in turn increasing the environmental impacts of agricultural and livestock production. People in developing countries such as Brazil, China and India are experiencing greater wealth and therefore have greater purchasing power. This purchasing power is often linked to adding more meat to their diets. In China this has caused a substantial westernisation of diets, entailing a rapid increase in the demand for meat. More than half of the 107 million tons of pork eaten worldwide in 2013 were consumed in China.

Land use

Currently 80% of the world’s agricultural land is used directly or indirectly for animal production. In the US over half the total land mass is used for the production of meat and dairy products. In Australia about two thirds of land is given over to farming production: about 90% of farm land is for grazing on native pastures. The irony is that the more arable land we use, the more arable land we need. Farming increases topsoil loss and soil degradation, which steadily decrease the productivity of farm land.

Even though the amount of grain produced in the world today is enough to feed the world’s human population twice over, 70% of this grain is fed to livestock. In 2010 the global production per capita of grain was 323kg. Only half of the 2010 harvest was used directly for food; the other half was used for animal feed or for bio-fuels. The FAO has predicted that the percentage of grain used directly by humans will fall even further, as developing countries emulate the dietary habits of westerners. It has been argued, on both geopolitical and ethical grounds, that it would be better to re-deploy this production in an attempt to meet the nutritional needs of the world’s poor rather than feed it to animals who will then be slaughtered to cater to the culinary tastes of its middle class.

Water

The harsh reality is that there will not be enough water available to produce enough food for the expected 9 billion population in 2050 if we adhere to current dietary trends across the globe. In terms of water availability, a study undertaken at the Stockholm International Water Institute warned that the world’s population may have to convert almost completely to a vegetarian diet over the next 40 years to avoid catastrophic shortages. Currently 70% of all available water goes to agriculture.

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Currently 70% of all available water goes to agriculture. 

According to the FAO food production will need to increase by 70% by 2050. However this will have huge ramifications for our already-stressed water resources. Humans derive about 20% of their protein from animal-based products. The Stockholm International Water Institute has warned that this percentage will need to drop to 5% by 2050 if we are to feed the extra 2 billion people expected to be living on the planet by then. 

The FAO has suggested that adopting a vegetarian diet is one option to increase the amount of water available to grow more food in an increasingly climate-erratic world. Producing animal protein-rich food consumes five to ten times more water than producing food for a vegetarian diet. One third of the world’s arable land is used to grow crops to feed animals. Other options to feed people include eliminating waste and increasing trade between countries in food surplus and those in deficit.

Greenhouse gas emissions and global warming

A 2006 report by the FAO found that our meat-heavy diets cause a greater amount of greenhouse gases (CO2, methane and nitrous oxide) in the atmosphere than either transportation or industry. Current meat production levels contribute approximately 22% of the 36 billion tonnes of greenhouse gases the world produces every year. The huge impact of the livestock sector on global warming is often overlooked. A global transition towards a low meat diet may reduce the effects of climate change by as much as 50% by 2050.

It is evident that livestock production requires more land, water, fossil fuels and other resources than the production of edible crops. The United Nations (UN) has also identified the livestock industry as “one of the most significant contributors to today’s most serious environmental problems, including global warming (livestock are responsible for 18% of greenhouse gas emissions, which is higher than the share of greenhouse gas emissions from transportation, loss of fresh water, rainforest destruction, spreading deserts, air and water pollution, acid rain, soil erosion and loss of habitat).”

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Conclusion: Vegetarianism is not enough

Although there are powerful arguments against over-consumption of meat and dairy products by wealthy populations in the context of global food security, blanket advocacy of universal vegetarianism may be too simplistic a prescription. To quantify the entire impact of meat consumption on global food security would require highly sophisticated computer technology that analyses how purchasing decisions on a micro level effect macro systems, including farming systems, global supply chains, and food markets.

One study conducted by the International Food Policy Research Institute found that if the western world halved their meat consumption per capita, the demand for meat would fall and prices would decline. This would make meat globally more affordable, which would have the greatest impact for those in developing countries who would be able to increase their animal-protein consumption. This would have substantial nutritional benefits, especially for children.

However the study also suggested that eating less meat could compromise food security. For example, if consumers in developed nations replaced meat with wheat-based products global wheat prices would rise. This in turn would effect the prevalence of malnutrition in developing countries which rely on wheat.

Although there are many benefits of vegetarianism, the complexities of global markets and human food traditions could produce some counterintuitive results. A serious discussion about food security and natural resource consumption must emphasise redistributive social justice and not only lifestyle choices. It would be incredibly difficult to persuade people to eat less meat, due to overall popularity of meat and the great variety of factors that influence food practices. In Western countries these habits are strongly reliant on a chain of industrialised activity that produces “highly standardised meat products, commonly sold in supermarkets and de-animalised to avoid reminding customers about the link between the meat dish and the killing of the animal.”

What we learn from the application of market economics to global human welfare may be that there is no one global solution, only partial solutions that may provide food security or environmental gains in particular contexts. The hopeful prospect of aggregated individual responsibility solving diabolically complex global problems has rarely been fulfilled in human history when the prosperity of powerful elites has been in the balance. Perhaps when a meeting of the G20 group of wealthy nations places the food security of developing nations and environmental health higher on its agenda than growth the situation may begin to turn around.

References
13. UNICEF. Progress For Children: A World Fit For Children Statistical Review. 2006 [cited


I use homoeopathy a lot and have done for some time. I know it works and I rely on it to assist my clients in getting well. But how do I know that it’s the homoeopathy that’s working and not something else that’s occurring in the consultation? How do I know that the people who come into my clinic wouldn’t have recovered their health without any intervention from me? How do I know that giving them a placebo, some sort of inert material, or some other form of medicine, wouldn’t have worked as well as or even better than a homoeopathic? Properly designed research can be, and has been, done to answer these questions, and the best of it removes every possible variable from the equation so that we know conclusively that the intervention being tested either worked or didn’t. Research results are a valuable resource and following are summaries of some of the more recent or recently unearthed work done to confirm the effectiveness of homoeopathy.

**Human Research**

1. Mathie RT, Farrer S. *Outcomes from homeopathic prescribing in dental practice: a prospective, research-targeted, pilot study. Homeopathy*, 2007, 96, 2, 74-81. This paper presented the results of a study into the effectiveness of individualised homoeopathic medicines for the management of common dental complaints and the effectiveness of a specific protocol used to collect such data. Fourteen dentists who routinely practice homoeopathy contributed data to the study, and data from the observations of and by 726 individual patients were collected. Of the 496 patients who were able to be followed up, 90.1% reported a positive outcome, 1.8% experienced a deterioration of their condition and 7.9% reported no change.

2. Matusiewicz R. *The effect of a homoeopathic preparation on the clinical condition of patients with corticosteroid dependent bronchial asthma. Biomedical Therapy*, 1997, 15, 3, 70-74. In this double-blind, randomised, placebo-controlled study, 40 people suffering from corticosteroid-dependent bronchial asthma were given either placebo or a combination homoeopathic formula every 5 to 7 days by subcutaneous injection. Using standard spirometry and granulocyte function to measure the response, researchers found that the combination product provided superior results to placebo.

3. Milewska G, Trzebiatowska-Trzeciak O. *Homoeopathic Treatment of Alcohol Withdrawal British Homoeopathic Journal*, 1993, Oct, 82, 249-251. Alcohol withdrawal and delirium tremens experienced by 30 alcoholics were the focus of this uncontrolled study carried out in a Polish medical clinic. Patients were treated with individualised homoeopathy and their progress was followed for two months. The treatment resulted in a reduced duration of alcohol withdrawal time and delirium tremens in all patients.

4. Mohan GR, et al, *Cervical Spondylosis - a Clinical Study, British Homoeopathic Journal*, 1996, Jul, 85, 131-133. In this uncontrolled study, 154 people suffering from cervical spondylosis were prescribed either homoeopathic Calcium fluorite, or a remedy selected via repertorisation of their mental and physical general symptoms, and their progress was monitored for one year. Of those given Calc fluor, clinical improvement was seen in 60% of cases. Forty-eight percent of those given the remedy arrived at by repertorisation reported clinical improvement.

5. Mojaver YN, et al. *Individualized homeopathic treatment of trigeminal neuralgia: an observational study. Homeopathy*, 2007, 96, 2, 82-6. This uncontrolled study, carried out in the Department of Oral Medicine at Iran’s Rafsanjan University of Medical Sciences, was designed to discover if individually prescribed homoeopathic medicines could provide relief from medically diagnosed trigeminal neuralgia. Fifteen people suffering from the condition were enrolled in the study and after receiving their individual prescriptions they were assessed monthly using a Visual Analogue Scale to gauge the severity of their symptoms. After the results were assessed at four months it was found that individualised homoeopathic treatment was associated with an average reduction in pain intensity of more than 60%.

6. Müller-Krampe B, et al. *Effects of Spascupreel versus hyoscine butylbromide for gastrointestinal cramps in children. Pediatr Int*, 2007, 49, 3, 328-34. In this observational cohort study, 204 children under 12 years of age suffering from gastrointestinal spasms and cramps were given either hyoscine butylbromide, a drug commonly prescribed for these conditions, or Spascupreel,
a homoeopathic complex. After a one week period of treatment the results of these interventions were assessed by a practitioner reviewing reports from the children’s parents or carers, using severity of spasms, pain or cramps, sleep disturbances, eating or drinking difficulties, and the frequency of crying to measure outcomes according to a four point scale. Analysis of the results showed that both medicines provided similar levels of benefit.

**Animal Research**
1. Graunke H, et al. Treatment of lowland frogs from the spawn stage with homoeopathically prepared thyroxin (10C-30C). *Scientific World Journal*, 2007, 22, 7:1697-702. In this project, performed at the Interuniversity College for Health and Development in Graz, Austria, lowland frog spawn were exposed to thyroxine potentised to 30C to determine the effect, if any, of this remedy on the development of the spawn into two- and then four-legged frogs, when compared to controls. It would be normal for the development of frog spawn to be accelerated by exposure to material levels of thyroxine. In this instance, exposure to 30C thyroxine produced a statistically significant reduction in the speed of development from spawn to four-legged lowland frogs.

2. Kumar KH, Sunila ES, Kuttan G, et al. Inhibition of chemically induced carcinogenesis by drugs used in homoeopathic medicine. *Asian Pac J Cancer Prev*, 2007, 8, 1, 98-102. In this study, carried out at the Amala Cancer Research Centre in India’s Kerala State, rats and mice were treated for the development of liver tumours using homoeopathic Hydrastis, Lycopodium, Phosphorus, Ruta or Thuja. Assessment was made on the basis of the development of tumours and their corresponding biochemical markers such as gamma-glutamyl transeptidase, glutamate pyruvate transaminase, glutamate oxaloacetate transaminase and alkaline phosphatase in the serum and in liver. Of the five medicines tested, Ruta (in a 200C potency) and Phosphorous (in a 1M potency) provided the most benefit.

**Plant Research**
1. Betti L, et al. Effectiveness of ultra high diluted arsenic is a function of succussion number as evidenced by wheat germination test and droplet evaporation method. *Int J High Dilution Res*, 2013, 12, 4, 127-128. Proceedings of the XXVII GIRI Symposium; 2013, Sep, 03-04; Bern (Switzerland) 127. This Italian research was performed to determine what effect, if any, the number of succussions used in the preparation of a homoeopathic medicine has on its activity. Previous research has shown that homoeopathically prepared potencies applied to arsenic-stressed wheat seeds stimulate their germination rate. In this study multiple replications of this model were employed using controls and a 45X homoeopathic potency of arsenic trioxide succussed 4, 8, 16, 32, 40, 70 and 100 times. On analysis of the results it was shown that increasing the number of the succussions increased the activity of the arsenic 45X.

**In-Vitro Research**
1. Ive EC, Couchman IM, Reddy L. Therapeutic Effect of Arsenicum album on Leukocytes. *Int J Mol Sci*, 2012, 13, 3, 3979-87. Scientists from South Africa’s Durban University of Technology performed this in vitro study to determine the effects of various succussed and unsuccussed homoeopathically prepared Arsenic trioxide (Arsenicum album) on human T-lymphocytes grown in tissue culture. Cells were intoxicated with arsenic trioxide and then exposed to succussed and unsuccussed Arsenicum 6C, succussed and unsuccussed Arsenicum 30C, succussed and unsuccussed Arsenicum 200C or a control substance for 24, 48 or 72 hours. Cells were assessed for viability at baseline and at these three data points. After the counts from these data points were assessed it was shown that, when compared to controls, all of the homoeopathically prepared Arsenicum potencies provided a statistically significant increase in cell viability. These results were unaffected by whether the material was succussed or unsuccussed, but were affected by the length of exposure time to the remedy.
During the months of July and December of 2014 I had the good fortune to become involved in providing massage and teaching Qigong to a community of Balinese people with a wide range of disabilities. I did this on a voluntary basis and intend to continue this work into the foreseeable future. My desire to do this work was as much a result of my passion for disability massage and Qigong as of my lifelong love of Southeast Asian culture and peoples.

The community of approximately 20 people with disabilities is located in a small village called Tampaksiring in central Bali and as such it is somewhat off the tourist trails. Tampaksiring is at a slight elevation and therefore has a slightly cooler climate than much of Bali. The community, called ‘Yayasan Cahaya Mutiara Ubud’, comprises people of varying ages (from 15 years upwards) with a varying range of disabilities. ‘Yayasan Cahaya Mutiara Ubud’ roughly translates as ‘Shiny Pearl Foundation Ubud’. However, Ubud is not the location of the community, though its title might suggest that it is. Its location is in the district of Gianyar.

In this paper I would like to reflect on the importance of trust, intercultural appreciation and respect, by drawing on key factors that influenced my approach to providing massage and Qigong instruction to people with disabilities in a Balinese community.
VISIT 1 - JULY 2014 - MASSAGE
The few months preceding my arrival in July were an extremely important time, as it involved communication via e-mail between the members of the Yayasan (Foundation) and myself. I cannot overstate how crucial this time was with regard to the success of the program I was attempting to put together. All communications regarding who I was, what visa I would need, possible dates, sponsor letter, where we could acquire a massage table etc., were relayed to the Yayasan so that they would not feel that they were just a group of people at the end of a process. The intention was to encourage them to feel in every sense that they were central to the proceedings. During July the entire time was for providing massage only.

In all I spent 16 full days providing massage at the Yayasan and a number of days simply visiting and helping with the cleaning or gardening, as well as attending a public performance of Traditional Balinese Dance that five of the members perform from their wheelchairs.

The first day of my visit to the Yayasan was spent talking, exchanging pleasantries and just generally getting to know each other. Again I stress the importance of this time. This gave the members an opportunity to listen to what I had to say, to ask questions, to get a sense of who I am. Equally it gave me the opportunity to ask questions of them - how would they like me to conduct the sessions, what degree of undress are they happy with for the massage sessions, what sensitivities (cultural or otherwise) do I need to take into consideration? Essentially it was an opportunity to ease myself into their way of life - not the other way around! Realistically speaking, they were my teachers and I was a newcomer whose specialty was in massage and Qigong. I still continue to look at myself in this role with humility and never assume to know anything or do anything other than what I am there for in the first place.

The conditions of disability that the members presented with on that first day included genetic and acquired illnesses. I was interested to discover that poliomyelitis was largely responsible for close to 50% of disability within the group, the vaccination for this disease having been introduced to Indonesia only just over one decade ago. Some genetic conditions include missing bones and also what they refer to, in the Indonesian language, as ‘tulang rapuh’ or brittle bones. Other conditions include amputation, premature birth defects, osteoporosis, spinal injuries and more. More often than not, this array of conditions goes alongside various complaints such as fatigue, feeling cold or hot, swollen and...
aching joints, constipation, numbness and tingling feelings (mainly in legs and feet), headaches, skin disorders, hernias, ulcers, insomnia, dizziness, pneumonia, and more.

“The Conditions of Disability that the Members Presented with on That First Day Included Genetic and Acquired Illnesses. I Was Interested to Discover That Poliomyelitis Was Largely Responsible for Close to 50% of Disability Within the Group, the Vaccination for This Disease Having Been Introduced to Indonesia Only Just over One Decade Ago.”

During the first few days of massage I concentrated primarily on providing relaxation massage, as most of the members expressed the idea that it would be nice to imagine they were in a spa environment (spas are very popular at tourist attractions in Bali). There was a storage room at the Yayasan and we decided that this would be our ‘spa’. We set up the room to suggest a spa as best we could by moving much storage material to another location and then installing the massage table, candles, incense and gentle music.

I felt that it was important that other members were also present during the massage sessions so they could all see what was happening and be given an opportunity to comment on it should they choose. Another reason for this decision was to make sure that they could see that no sexual abuse would occur. This is an important point, as people with disabilities are obviously extremely vulnerable. As it turned out, achieving this was no problem as it is in the nature of Balinese people to be gregarious so for a lot of the time the room would be quite full of people talking, laughing, putting out offerings to the gods and generally participating in the experience. This tends to be quite contrary to how we in the West conduct our massage, with our quiet rooms and closed doors. For me the experience was exhilarating and I soon felt comfortable enough to participate in the general chitchat of the room while continuing to conduct the massage session. As the trust between us grew I came to realise that this was completely appropriate and would possibly have seemed quite odd, perhaps even rude, were I to maintain a solemn practitioner’s silence. An Indonesian/Balinese concept that is quite applicable here is ‘rama tama’, which roughly translates as ‘joyfully crowded sociability’.

As time went by and we became more familiar with each other I would, every so often, add a few more techniques. Acupressure points for headache or expelling heat were becoming very popular. After a short time they asked me to be more specific with regard to applying techniques that might help their various complaints and very shortly remedial techniques were starting to become an everyday part of the sessions. We continued in this manner throughout the rest of the visit.

I believe that as massage therapists in the West we tend to have certain expectations as to how a good session should be conducted. The client arrives appropriately early, we enquire as to their condition, in modesty we leave the room as they undress, the client will already be lying on the massage table as we re-enter the room, and we give a massage for an allocated amount of time. Essentially the format of the entire session has been constructed by us and our clients generally comply, and to all intent and purpose it works well for us. However, for this Balinese community it is not quite the same. There are no care workers. There is no machine to lift a person from the wheelchair. Transfers to and from the massage table have to be done without anyone to help. Undressing and dressing is often difficult, as are finding a comfortable position to lie on the table, turning from a supine to a prone position, draping, and indeed the massage process itself, as mostly clients’ bodies are not conveniently straight. Sometimes the only way a person could receive a massage was if I helped out with the transfer. This was hard cooperative work between the client and myself, and a great deal of care had to be taken so as not to cause pain or injury to either of us. Sometimes the nature of the disability meant that my client was unable to get onto the table. This was due either to their being unable to rise from the wheelchair to the height of the massage table or to lie on the table due to body shape, discomfort or pain. In such cases I would perform the massage while my client was in the wheelchair.

Another point of interest regarding the nature of the community was that if more people arrived at the Yayasan at any stage of the day then we had to make attempts to fit all of them into the remainder of that day. This is simply the way it was done. The Balinese way of life is community-based and it is therefore important that no one is neglected. In this manner the length of the sessions, particularly later in the day, could range anywhere from 20 minutes to one hour. On further analysis I believe that this communal approach to the massage process is a complete therapy in itself. On being asked, “How do you all maintain such everyday joy?” the Yayasan leader replied, “When we hold hands together we are strong.”

Visit 2 - December 2014 - Qigong & Massage

During the December visit I included teaching Qigong alongside providing massage. This was at the instigation of
the group, after discussions during the first visit. I decided to teach to them the First Shibashi Qigong set. It is one of the easiest to learn, can be performed from a chair and its benefits can generally be felt right from the start. During the time I was there those who chose to be involved in the classes had successfully learned nine of the forms. The format for each session encompassed a warm-up and the forms themselves.

After the first session everyone said they loved it because it was easy and they could feel heat and tingling in their hands. Another common experience of feeling Qi was reported by one member while we were performing ‘holding the ball’. In this instance he called out with great excitement ‘I can feel it’, referring to a sensation in and between the hands that feels like holding two magnets repelling each other. No one reported any feelings in their legs or feet, but I am hoping that this feeling will at some stage start to move down to their legs, as these are the parts of their bodies that are most often affected by their conditions, as well as from spending much of the day in a wheelchair.

During another Qigong session one of the youngest members (15 years old), who was not present during any of the previous sessions, picked up all four of the previously taught forms extremely easily and was the first to fully understand Form Five. With his help we had everyone doing Form Five by the end of the session. This young person is also one of the Traditional Balinese Dancers mentioned previously and I believe his understanding of Balinese Dance, as well as possessing the coordination required, enabled him to gain an insight into what we were trying to achieve.

As the Qigong sessions progressed the feeling of Qi in the hands was becoming second nature to participants but still not evident in other parts of the body. I believe this will take a while to achieve, due to posture, position in the wheelchair, physical disabilities and Qi blockage. I suggested to them that as time goes by they might start to feel these same sensations throughout the entire body and I am hopeful that it may eventually encourage a sense of lightness and health throughout. If so, being able to achieve this at any time they wish by doing a simple exercise would, I believe, be quite empowering and relieving for them.

During the first few days it was necessary for massage to take place on beds as our borrowed massage table had been taken away after my return to Australia at the end of July. This was a particularly difficult period for me to give massage and for the members to receive massage. However one member did actually benefit from this compromised situation. During my previous visit in July I was providing massage to him in his wheelchair as he was unable to get onto the massage table. This time he decided to follow suit and have massage on his bed. Because of this I was able to massage parts of his body that previously I could not reach. He mentioned in one of these sessions that he was so happy to be feeling good and pain-free. It was also during this session that he fell asleep.

After a number of days I managed to buy a massage table with the help of a generous Australian donor. I had been wanting to purchase a table that could belong to the Yayasan and this was my opportunity. With the new table finally located back in our ‘spa’ the sessions proceeded as they had in July, apart from the above-mentioned member, who elected to continue to have his massage on his bed.

I am returning to Bali again in July 2015 to continue the massage program. At the request of the Yayasan members I am presently looking for suitable massage therapists who would be interested in donating some of their time for this group, at times when I am unable to be there myself.

I feel I have been privileged to have this experience and I look forward to spending time again with this wonderful group of people in July 2015. I would like to thank every one of the members of ‘Yayasan Cahaya Mutiara Ubud’ for welcoming me into the family.
“Giving back to industry is my mission and it warms my heart to see so many in the trade hand down their knowledge and culinary wisdom.”

What is your career history?
I retrained in natural medicine in 1999 and have continued to raise awareness about the benefits of organic food ever since. A passionate entrepreneur, I founded my globally recognised business Gowings Food Health Wealth in 2000, which provides culinary and marketing solutions to the wellness industry. In 2008 I moved from the gritty inner Melbourne suburb of Collingwood to lush Byron Bay to further my holistic study, research, and to surf the pristine waters of the north coast. I have practised nutrition, food as medicine and as a business coach to the wellness industry for 13 years.

What have been the major influences on your career?
The main influence on my career was Paul Pitchford, an American nutritionist. I trained under him in 2010. He uses whole food nutrition and combines Eastern and Western therapies to promote health and wellbeing.

What do you most like about being a natural medicine practitioner?
Bringing about change in people’s lives.

What advice would you give to a new practitioner starting out?
I encourage all who enter to arm themselves with accredited tertiary qualifications, work hard, study harder – and be a shiny role model for all who follow.

What are your future ambitions?
I am of the firm belief that wellness is part of the multi-coloured brick road that paves the way to happiness. The pursuit of happiness is fundamental to our consciousness, and is a mezze of attributes including health, abundance, wellness, wealth, grief, joy, love and the spiritual pursuit of inner peace. The need to thrive is beyond raw food, yoga moves and green smoothies. It is about finding our innate self, our essential nature and allowing all of these aspects to integrate into ourselves.

My next stop is Toronto via NZ to visit two leading health retreats and observe or tweak their menus. I always wanted to travel for work and so I created a great job where my Surf Spa Food philosophy helps leading hotels, spas and health retreats create world-class menus.

I am currently enrolled in a Master of Gastronomic Tourism program with Le Cordon Bleu. When I receive good grades it is certainly a highlight and I’ve been encouraged to apply for a scholarship to finish the degree in France later this year. Wish me luck!!

Giving back to industry is my mission and it warms my heart to see so many in the trade hand down their knowledge and culinary wisdom. I feel we need greater communication between the mainstream media and food industries to demonstrate how effective natural medicine is and to encourage them to be less suspicious.
A lease is a legally binding contract between you and a landlord. It allows you to occupy premises and tells you what you can and can’t do, and your and the landlord’s rights.

Generally a lease exists and starts once it is signed by both parties. Sometimes it can start earlier if the landlord has given you permission to go in before it is signed. Sometimes an ‘early access’ arrangement exists, where tenants can enter the premises early to measure up or start cabling etc. A lease can also be registered. In most states, if a lease runs for longer than three years it must be registered, giving the public notice that the tenant has a recognised interest in the property.

Another type of lease is a retail lease. These are leases where there is a shop front, or where the premises are in a shopping centre. A retail lease can also exist if the tenant is open to the general public for selling goods and services. If this is the case, there is legislation in each state and territory specifically covering retail leases. In most states the legislation is called the Retail Leases Act, or a variation of that name.

Some things you should do before signing a lease
1. Get a draft copy of the lease long before you need to sign it. Read it carefully and get some advice before you sign it so that you understand what you are getting into.

2. Do some market research about the area you are looking at. Find out the average rent and any proposed changes that could affect your business. For example, is there a proposed motorway being built outside your shop? It is also important to look at vacancy rates in the area. Are shops vacant for a long...
time before being re-leased? Are there council zoning laws that restrict what type of business can be run?

3. Consider your business needs. Is the space you are looking at right for your business? Think not just about now but about several years into the future. Is there scope to expand your business? Do the premises suit your needs? Is the space too hot or too cold, too dark or too damp? Will it support the ambience you are trying to create? Can you fit in everything you need? Can you work in the space comfortably and easily?

4. Review the lease. There are certain things to look out for and you should make sure that you understand your rights and are happy with them.

(a) How are the premises described? Is there a floor plan? Make sure that the premises you’ve seen match up with what’s on the lease.

(b) Are there particular fittings included? Does the lease include blinds, light fittings, air conditioning units etc? If so, make sure that they are listed and in good condition.

(c) What is the term of the lease? Is there an option to renew the lease when it expires? Make sure that the lease is long enough for you to build good will in your business and get it off the ground, but not so long that you are locked in long after you want to leave. Many leases are for three to five years with an option to renew for another similar period. An ‘option to renew’ means that when the lease is about to expire the landlord must offer it to you first. You can decide whether to continue with it or not. Most of these options are exercised three to six months before the lease expires to give both sides enough time to make arrangements. Don’t let the lease end before you make your decision, as the landlord won’t be obliged to accept the renewal and can find a new tenant.

(d) What uses are allowed under the lease? Some leases list permitted uses for the premises. Do they suit your purposes? Some leases are specific about what businesses can and can’t be run in the premises. There could be a council restriction or one stipulated by a shopping centre which may already have negotiated an ‘exclusive usage’ clause with another tenant. Exclusive usage clauses mean that there can only be one type of a given business in the centre.

(e) How much is the rent and when is it payable? When and how often will the rent be reviewed? Can you afford this rent? Be realistic about it.

(f) What are the outgoings? Do you have a right to review these? Under some leases the tenant must pay for all utilities, and even pay the rates. Always check how much these will be.

(g) What is the security required? Do you need to pay a bond and rent in advance? Many retail leases ask for three months’ rent in advance as well as a bond.

“IS THERE AN OPTION TO RENEW THE LEASE WHEN IT EXPIRES? MAKE SURE THAT THE LEASE IS LONG ENOUGH FOR YOU TO BUILD good will in your business and get it off the ground, but not so long that you are locked in long after you want to leave.”
(h) Do you need permission to make any changes to the premises? Some leases allow you to paint or hang pictures without permission but others don’t. Always check before you make changes.

(i) What is ‘fair wear and tear’? What damage and repairs are you responsible for and what is the landlord responsible for? Tenants are not usually responsible for fair wear and tear of the premises but what is fair wear and tear? Generally carpet that is worn will be covered but carpet damaged by cigarettes, or holes in walls, won’t be.

(j) Are there any shared spaces? How are these shared and what are your rights? How much will you have to pay for these? In many multi-practice premises there may be a shared reception or waiting room, bathroom, and even staff facilities. There may also be car parking spaces allocated to you. It is important to know how much you will need to pay and how often. Also, find out about displaying your signage in these common areas.

(k) What does the termination clause say? How much notice will you need to give and how much notice will the landlord need to give? Are there any circumstances where this notice period is shortened? These clauses give people the most grief. For retail leases the notice period can be six to twelve months, so as to be fair to both sides. If you want to leave early you may be able to, but you may still have to pay rent for the remainder of that time. Often too a landlord may terminate the lease with little notice if you have broken one of the lease terms. It is important that you always follow what is set out in the lease to avoid this.

(l) If you want to sell or close your business, can you get out of your lease early? Some leases will allow you to assign the lease to the new business owner while others won’t. If you sell your business the landlord may choose not to lease to the new owner. You need to check this before negotiating.

(m) Can you sublet the whole or part of the space? Some leases allow you to do this and others don’t. Always check with this before you rent out a room to another practitioner. This is different though to having another practitioner coming in and using your space for a day a week.

(n) What are your rights to access of the premises? If you are in a shopping centre can you enter the premises after hours? Can you be forced to open or close when you don’t want to? You need to think about your business hours and whether the lease suits you. For example, if you have a room at the back of a store that closes at 5 pm and you can’t get access after that, how will that work for your business? Some shopping centres may be forced to close on certain days due to council restrictions, so how will that affect you? If the shopping centre requires all their tenants to open for later hours before Christmas will you have to as well?

(o) Will you need to take out insurance for anything as the tenant?

(p) Is there a ‘make good’ clause? Do you need to remove your fit-out and return the premises to their original condition when you leave? A ‘make good’ clause means that you will leave the premises as you found them. It is always a good idea to take a photo before you make any changes. Some landlords will allow you to leave changes you have made. Always check, as you will continue to pay rent until the premises are returned to their original state if that is what is required under the lease.

(q) Are there a written condition report or photos of the premises before you moved in? Does this note any damage or defects that already exist?

(r) Will you need to do regular renovations such as re-painting and re-carpeting? Can the landlord force you to do so even if you don’t want to? In some shopping centres tenants are made to renovate at regular intervals whether they want to or not. They may also be required to use the landlord’s renovators.

(s) Can you be forced to relocate your business if the landlord decides to renovate or rebuild? Some leases state that if a landlord wants to do major renovations they can force the tenants to leave early. How will this impact on your business?

5. Sign the lease but only after you’ve made sure that anything you’ve negotiated is now in the lease. Inspect the property and take photos as a record. Remember, don’t sign a lease without reading it first!

Finally some tips for being a good tenant:

• Build a good relationship with the landlord.

• Always pay your rent on time.

• Keep your insurance up to date.

• Get the landlord’s consent for things you need to before you do them.

• Start renewal negotiations early if you plan to stay on.

• If there are any problems with the landlord sort them out quickly before they become insurmountable.
Collaboration the key to tackling fraud

nib Media Release

A 2010 report* by the World Health Organisation cited fraud as one of the 10 leading causes of inefficiency in the healthcare industry, with an average of just under 7% of expenditure lost annually on fraud.

For Australian health insurers, that translates to a loss of many millions of dollars each year, which places excessive pressure on claims inflation and ultimately impacting policyholder premiums.

Health insurance fraud can take a number of forms, from simple mistakes and errors that can lead to incorrect payment, through to intentional deception or misrepresentation.

Specific examples of fraud include:
• Billing for a higher level of service than was provided.
• Charging for services not provided.
• Using someone else’s available benefit to pay for a service.
• Submitting duplicate claims.
• Using an inappropriate code for a service provided.

nib is continually faced with the challenge of minimising claims inflation, which typically runs at twice the rate of CPI, and in doing so, reduce premium increases,” Mr Vaughan said.

“Addressing the rate and impact of fraud is significant in managing our overall claims costs.

“Our sophisticated systems allow us, for example, to track the number of claims a massage therapist makes in a day. If it’s significantly more than what is deemed as industry standard, the provider is flagged and we will undertake further investigation,” Mr Vaughan said.

“We also have the ability to examine aggregated claims data over a period of time, which can detect exceptions in claiming, while our reporting tools also highlight specific behaviours by providers that we see as a potential breach of claiming rules.

“As well as our own data, we also receive information and ‘tip-offs’ of fraudulent activities from the general public and industry insiders that we follow-up and investigate,” he added.

nib also works collaboratively with other health funds and industry bodies in the fight against fraud.

“The collective approach is imperative. Almost every health fund is currently represented on the Private Health Care Australia’s Fraud and Security committee, which meets regularly to discuss trends and share information regarding industry fraud,” Mr Vaughan said.

“It is an industry-wide problem that can be reduced by working together to address the underlying issues and developing solutions that will benefit the consumer, health funds and ultimately the industry as a whole.”

Mr Vaughan said that while detection is critical, better education for providers as well as working with Associations to establish and enforce industry standards regarding fraudulent practices, is critical in arresting the growing trend.

“There are some cases where providers are not aware of their obligations or they make genuine mistakes,” Mr Vaughan said.

“While these are not excuses for undertaking illegal practices, it’s important that we continue to work with these providers and their Associations to ensure they have access to the right information and are fully aware of their compliance obligations when operating in this industry.

“However, there are still many cases of continued and intentional attempts to receive payments by deception. These actions have far greater consequences including deregistration by their Association meaning providers can no longer practice.

“In the most serious cases providers can face criminal charges,” he added.

Providers who are unsure of their obligations or require further information regarding claiming practices are encouraged to contact the Australian Tradition Medicine Society.

* The Financial Cost of Health Care Fraud 2014 by Jim Gee and Prof. Mark Button Centre for Counter Fraud Studies, University of Portsmouth, UK, March 2014
Clinical Guide to Musculoskeletal Palpation

Reviewed by Sandra Grace


Palpation is a widely used method of detecting the presence and effects of many musculoskeletal conditions and injuries. The authors of this book make it clear that to palpate sympathetically and sensitively is as important as to palpate on the basis of research and evidence. The authors identify two main goals of palpation: i) identifying anatomical structures in a patient, and ii) assessing these structures. The book addresses these goals using a step-by-step guide through regions of the body. The survey of each region deals with function, bony anatomy, soft tissue anatomy, neuroanatomy and palpation – an approach that serves to enhance the reader’s understanding of anatomical and palpatory relationships. Each chapter ends with a case study that presents a case history and examination and questions about likely diagnoses. Case solutions provide the structures to be palpated, likely palpatory findings and clinical reasoning used to help rule and rule out diagnoses. The case studies are good exemplars of the way palpatory findings can contribute to clinical reasoning in the context of a full case history and physical examination. The artwork and photos are excellent supports to the text and an image bank is included as an educator’s resource: all the book’s tables, figures and photos are available for lesson presentations and handouts.

The introductory chapter highlights the importance of palpation in patient examination and describes the palpatory technique for identifying and assessing different structures, including skin temperature, oedema, tissue mobility, hydration and tophic changes. Each chapter contains a ‘clinical pearl’ – a collection of valuable tips for clinical practice. This book’s clarity and completeness should greatly enhance students’ and beginning clinicians’ task of integrating knowledge and technical skill.
Support the Mountain – Nutrition for Expanded Consciousness

Reviewed by Christine Gruetke


TV cooking show culture may be shaping our awareness of food as a visual feast, entailing the potential side effect of a ‘socialisation’ and ‘commercialisation’ of the topic at the expense of understanding and appreciating nutrition as a serious avenue towards health and wholeness. Good food and clinical reflexology/Bowen therapy can go hand in hand for practitioners who wish to explore simple and gentle body system-targeted nutrition as a client support option.

Mikio Sankey’s Support the Mountain is part of Esoteric Acupuncture, a philosophy that synthesises Traditional Chinese Acupuncture and Five Element Theory with Ancient Wisdom, naturopathy and the new physics of quantum, field and superstring theory. While one does not need to be a quantum physicist or acupuncturist to digest the material – J -, it helps to view ‘energy’ as a force consisting of both particles (tangible body) and waves (intangible consciousness).

Support the Mountain begins with germ theory as the model underpinning the Western pharmaceutical perspective and postulating that microscopic pathogens cause all human disease by attacking the body from the outside, implying that we have no control over manifesting illness. There is now a growing body of scientists who, based on the findings of new physics and new biology (and here specifically epigenetics and Bruce Lipton PhD), write about our thought and belief systems (waves) creating our biology (particles).

Sankey’s perspective aligns with the latter group, suggesting that ‘catching a bug’ is an internal quantum-level process where the immune system, weakened through excessively acidic and/or toxic blood (stress), vibrates at the level of a pathogen and therefore attracts the bug into itself through the concept of resonance. He concludes that a healthy mind and healthy blood allow the body to vibrate at a level that does not permit exogenous microbes to proliferate within it.

Support the Mountain explores the main mineral needed for the individual physical element as per Five Elements Theory and the energetic mineral to support this element. In addition to describing the physical energetics of the element along with symptoms and problems caused by an imbalance in it and a deficiency of its mineral, Sankey looks at the ‘higher energetics’ of the element.

Taking Liver (Wood element) as an example, this would be an ability to determine/plan direction in life and along with Gall Bladder the ability to carry things through with sound judgement. Liver’s energetic mineral is organic sodium – NOT salt (inorganic) – a mineral found mostly in plants and required by the blood (Fire/Heart, the ‘child’ of Liver) to keep calcium (from Water/Kidney) in solution to allow the blood to remain healthy and alkaline, leading to more joy and love in life. Sankey suggests that the fastest way to create healthy new blood cells is through eating greens (colour of Liver/Wood), bearing in mind that the molecular structure of chlorophyll and blood varies by only one atom.

The book’s very informative sections on enzyme deficiencies, related symptoms and problems and eating foods for Life are complemented by an explanation of the esoteric meaning of the book title and an addendum of common problems along with naturopathic suggestions.

Support the Mountain may be very useful to anyone seeking a much larger perspective on nutrition and specifically to practitioners who see value in body system-targeted nutrition from an Eastern perspective.
Primary insomnia is a common health issue in the modern world. We conducted a systematic review of the auricular therapy, aiming to evaluate whether there are advantages of auricular acupuncture with seed or pellet attachments for the treatment of primary insomnia.

**Methods:** A search of relevant literatures was performed on major medical databases, including Medline, Embase, CENTRAL, CBM, CNKI, VIP, Wanfang Data and so on. Risk of bias evaluation, meta-analysis, sensitivity analysis and evidence rating of all extracted information were conducted also.

**Results:** A total of 1381 records were identified, with 15 studies deemed eligible for the present review. Meta-analyses were conducted in two comparisons separately: participants received auricular acupuncture were more likely to make an improvement in clinical effective rate (RR = 1.40, 95% CI 1.07 to 1.83), sleep duration (MD = 56.46, 95% CI 45.61 to 67.31), sleep efficiency (MD = 12.86, 95% CI 9.67 to 16.06), global score on PSQI (MD = -3.41, 95% CI -3.92 to -2.89), number of awakenings (MD = -5.27, 95% CI -6.30 to -0.25) and sleep onset latency (MD = -10.35, 95% CI -14.37 to -6.33) when compared to sham auricular acupuncture or placebo; while in auricular acupuncture VS medications comparison, a better effective rate (RR = 1.24, 95% CI 1.15 to 1.35), better sleep efficiency (MD = 21.44, 95% CI 16.30 to 26.58), lower PSQI score (MD = -3.62, 95% CI -4.59 to -2.65) and less adverse effect (RR = 0.11, 95% CI 0.04 to 0.26) can be seen also in auricular acupuncture group. Although these results suggested benefits of auricular acupuncture, the overall quality of evidence rated by the GRADE system was low.

**Conclusion:** Statistical analyses of the outcomes revealed a positive effect of auricular acupuncture for primary insomnia. Nonetheless, considering the poor methodological quality, insufficient sample size and possible publication bias, current evidence is not yet adequate to provide a strong support for the use of auricular acupuncture in the treatment of primary insomnia. More strictly designed clinical studies will be needed to obtain a more explicit conclusion.


**Effects of electroacupuncture on recovery of the electrophysiological properties of the rabbit gastrocnemius after contusion: an in vivo animal study,** BMC Complementary and Alternative Medicine 2015, 15:69

Our preliminary studies indicated that electroacupuncture (EA) at the ST36 and Ashi acupoints could promote regeneration of the rabbit gastrocnemius (GM) by improving microcirculation perfusion, promoting the recovery of myofiber structures, and inhibiting excessive fibrosis. However, the effects of EA on recovery of the electrophysiological properties of the GM after contusion are not yet clear. Thus, the purpose of this study was to investigate the effects of EA at the Zusanli (ST36) and Ashi acupoints with regard to recovery of the electrophysiological properties of the rabbit GM after contusion.

**Methods:** Forty-five rabbits were randomly divided into three groups: normal, contusion, and EA. After an acute GM contusion was produced (in rabbits in the contusion and EA groups), rabbits in the EA group were treated with electrostimulation at the ST36 and Ashi acupoints with 0.4 mA (2 Hz) for 15 min. The contusion group received no EA treatment. At different time points (7, 14, and 28 days) after contusion, we performed surface electromyography (EMG) and measured the nerve conduction velocity (NCV) of the GM and the GM branch of the tibial nerve. We also examined acetylcholinesterase (AchE) and Agrin expression in the neuromuscular junction (NMJ) via immunohistochemistry.

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Results: Compared with the contusion group, the EMG amplitude and NCV in rabbits in the EA group were significantly higher at all time points after contusion. AchE and Agrin expression in the EA group were significantly higher than those in the contusion group.

Conclusions: Our results showed that EA at the ST36 and Ashi acupoints effectively promoted recovery of the electrophysiological properties of the rabbit GM after contusion. The effects of EA were realized by promotion of the regeneration of myofibers and nerve fibers, as well as acceleration of NMJ reconstruction by upregulation of AchE and Agrin expression in the motor endplate area.

Herbal Medicine

Mehmood MH, Munir S, Khalid UA, Asrar AnM, Gilani AH.


Background: Matricaria chamomilla commonly known as “Chamomile” (Asteraceae) is a popular medicinal herb widely used in indigenous system of medicine for a variety of ailments. However, there is no detailed study available showing its effectiveness in hyperactive gut disorders like, abdominal colic and diarrhoea. This study was designed to determine the pharmacological basis for the folkloric use of Matricaria chamomilla in diarrhoea.

Methods: The crude aqueous-methanolic extract of Matricaria chamomilla (Mc.Cr) was studied for its protective effect in mice against castor oil-induced diarrhoea and intestinal fluid accumulation. The isolated rabbit jejunum was selected for the in-vitro experiments using tissue bath assembly coupled with PowerLab data acquisition system.

Results: Oral administration of Mc.Cr to mice at 150 and 300 mg/kg showed marked antidiarrhoeal and antisecretory effects against castor oil-induced diarrhoea and intestinal fluid accumulation, simultaneously, similar to the effects of cromakalim and loperamide. These effects of plant extract were attenuated in animals pretreated with high K+. Pretreatment of tissues with GB blocked the inhibitory effects of cromakalim on low K+, while the presence of 4-AP did not alter the original effect. Verapamil, a Ca++ channel antagonist, caused complete relaxation of both low and high K+-induced contractions with similar potency. The inhibitory effect of verapamil was insensitive to GB or 4-AP. When assessed for Ca++ antagonist like activity, Mc.Cr at high concentrations caused rightward shift in the Ca++ concentration-response curves with suppression of the maximum response, similar to the effect of verapamil, while cromakalim did not show similar effect.

Conclusions: This study indicates that Matricaria chamomilla possesses antidiarrhoeal, antisecretory and antispasmodic activities mediated predominantly through K+-channels activation along with weak Ca++ antagonist effect.

Shakibaei F, Radmanesh M, Salari E, Mahaki B.


Objective: To evaluate the efficacy of Ginkgo biloba as a complementary therapy for attention-deficit/hyperactivity disorder (ADHD).

Methods: Children and adolescents with ADHD received methylphenidate (20-30 mg/day) plus either G. biloba (80-120 mg/day) or placebo for 6 weeks. Parent and teacher forms of the ADHD Rating Scale-IV (ADHD-RS-IV) were completed at baseline, week 2, and week 6. Treatment response was defined as 27% improvement from baseline in the ADHD-RS-IV.

Results: Compared with placebo, more reduction was observed with G. biloba regarding ADHD-RS-IV parent rating inattention score (-7.74 ± 1.94 vs. -5.34 ± 1.85, P < 0.001) and total score (-13.1 ± 3.36 vs. -10.2 ± 3.01, P = 0.001) as well as teacher rating inattention score (-7.29 ± 1.94 vs. -5.96 ± 1.52, P = 0.004). Response rate was higher with G. biloba compared with placebo based on parent rating (95.5% vs. 58.6%, P = 0.002).

Conclusions: The G. biloba is an effective complementary treatment for ADHD. Further studies with longer treatment duration are warranted in this regard. IRCT2014111519958N1.

Brancheau D, Patel B, Zughbi M.


Background: The use of herbal medications to treat various diseases is on the rise. Cinnamon has been reported to improve
glycolated hemoglobin and serum glucose levels. When patients consider the benefit of such substances, they are often not aware of potential adverse effects and drug interactions. Cinnamon, via coumarin, can cause liver toxicity. Therefore, its concomitant use with hepatotoxic drugs should be avoided. Case Report A 73-year-old woman was seen in the Emergency Department complaining of abdominal pain associated with vomiting and diarrhea after she started taking cinnamon supplements for about 1 week. The patient had been taking statin for coronary artery disease for many months. The laboratory workup and imaging studies confirmed the diagnosis of hepatitis. The detail workup did not reveal any specific cause. Cinnamon and statin were held. A few weeks after discharge, the statin was resumed without any further complications. This led to a diagnosis of cinnamon-statin combination-induced hepatitis. Conclusions A combination of cinnamon supplement and statin can cause hepatitis, and it should be discouraged.

**Homoeopathy**

Michalsen A, Uehleke B, Stange R.


**Background:** This non-interventional study was performed to generate data on safety and treatment effects of a complex homeopathic drug (Contramutan N Saft).

**Patients and Methods:** 1050 outpatients suffering from common cold were treated with the medication for 8 days. The study was conducted in 64 outpatient practices of medical doctors trained in CAM. Tolerability, compliance and the treatment effects were assessed by the physicians and by patient diaries. Adverse events were collected and assessed with specific attention to homeopathic aggravation and proving symptoms. Each adverse effect was additionally evaluated by an advisory board of experts.

**Results:** The physicians detected 60 adverse events from 46 patients (4.4%). Adverse drug events occurred in 14 patients (1.3%). Six patients showed proving symptoms (0.57%) and only one homeopathic aggravation (0.1%) appeared. The rate of compliance was 84% in average for all groups and the global assessment of the treatment effects attributed to “good” and “very good” in 84.9% of all patients.

**Conclusions:** The homeopathic complex drug was shown to be safe and effective for children and adults likewise. Adverse events specifically related to homeopathic principles are very rare. All observed events recovered quickly and were of mild to moderate intensity.

**Homeopathy in France in 2011-2012 according to reimbursements in the French national health insurance database (SNlIRAM). Family Practice. 2015, pii: cmv028. [Epub ahead of print]**

**Background:** The use of homeopathic medicine is poorly described and the frequency of combined allopathic and homeopathic prescriptions is unknown.

**Objective:** To analyse data on medicines, prescribers and patients for homeopathic prescriptions that are reimbursed by French national health insurance.

**Methods:** The French national health insurance databases (SNlIRAM) were used to analyse prescriptions of reimbursed homeopathic drugs or preparations in the overall French population, during the period July 2011–June 2012.

**Results:** A total of 6,705,420 patients received at least one reimbursement for a homeopathic preparation during the 12-month period, i.e. 10.2% of the overall population, with a
predominance in females (68%) and a peak frequency observed in children aged 0-4 years (18%). About one third of patients had only one reimbursement, and one half of patients had three or more reimbursements. A total of 120,110 healthcare professionals (HCPs) prescribed at least one homeopathic drug or preparation. They represented 43.5% of the overall population of HCPs, nearly 95% of general practitioners, dermatologists and pediatricians, and 75% of midwives. Homeopathy accounted for 5% of the total number of drug units prescribed by HCPs. Allopathic medicines were coprescribed with 55% of homeopathic prescriptions.

**Conclusions:** Many HCPs occasionally prescribe reimbursed homeopathic preparations, representing however a small percentage of reimbursements compared to allopathic medicines. About 10% of the French population, particularly young children and women, received at least one homeopathic preparation during the year. In more than one half of cases, reimbursed homeopathic preparations are prescribed in combination with allopathic medicines.

### Massage and bodywork therapies

**Birbes EL, Meeus M, Baert I, Nijs J.**


Traditional understanding of osteoarthritis-related pain has recently been challenged in light of evidence supporting a key role of central sensitization in a subgroup of this population. This fact may erroneously lead musculoskeletal therapists to conclude that hands-on interventions have no place in OA management, and that hands-off interventions must be applied exclusively. The aim of this paper is to encourage clinicians in finding an equilibrium between hands-on and hands-off interventions in patients with osteoarthritis-related pain dominated by central sensitization. The theoretical rationale for simultaneous application of manual therapy and pain neuroscience education is presented. Practical problems when combining these interventions are also addressed. Future studies should explore the combined effects of these treatment strategies to examine whether they increase therapeutic outcomes against current approaches for chronic osteoarthritis-related pain.

**Reid SA, Callister R, Snodgrass SJ, Katekar MG, Rivett DA.**


Manual therapy is effective for reducing cervicogenic dizziness, a disabling and persistent problem, in the short term. This study investigated the effects of sustained natural apophyseal glides (SNAGs) and passive joint mobilisations (PJMs) on cervicogenic dizziness compared to a placebo at 12 months post-treatment. Eighty-six participants (mean age 62 years, standard deviation (SD) 12.7) with chronic cervicogenic dizziness were randomised to receive SNAGs with self-SNAGs (n = 29), PJMs with range-of-motion (ROM) exercises (n = 29), or a placebo (n = 28) for 2–6 sessions over 6 weeks. Outcome measures were dizziness intensity, dizziness frequency (rated between 0 [none] and 5 [>once/day]), the Dizziness Handicap Inventory (DHI), pain intensity, head repositioning accuracy (HRA), cervical spine ROM, balance, and global perceived effect (GPE). At 12 months both manual therapy groups had less dizziness frequency (mean difference SNAGs vs placebo −0.7, 95% confidence interval (CI) −1.3, −0.2, p = 0.01; PJMs vs placebo −0.7, −1.2, −0.1, p = 0.02), lower DHI scores (mean difference SNAGs vs placebo −8.9, 95% CI −16.5, −1.6, p = 0.02; PJMs vs placebo −13.6, −20.8, −6.4, p < 0.001) and higher GPE compared to placebo, whereas there were no between-group differences in dizziness intensity, pain intensity or HRA. There was greater ROM in all six directions for the SNAG group and in four directions for the PJM group compared to placebo, and small improvements in balance for the SNAG group compared to placebo. There were no adverse effects. These results provide evidence that both forms of manual therapy have long-term beneficial effects in the treatment of chronic cervicogenic dizziness.

### Nutrition

**Giri AK, Rawat JK, Singh M, Gautam S, Kaithwas G.**


**Background:** Lycopene is a robust antioxidant with significant antulcer activity. Henceforth, the present study was ventured to elucidate the effect of lycopene on experimental esophagitis. Methods Groups of rats were subjected to forestomach and pylorus ligation with subsequent treatment with lycopene (50 and 100 mg/kg, po) and pantoprazole (30 mg/kg, po). Results Treatment with lycopene evidenced sententious physiological protection when scrutinized for pH, acidity (total and free), volume of gastric juices and esophagitis index. Lycopene further embarked diminishing effect on oxidative stress through synchronising lipid and protein peroxidation along with regulating the enzymatic activity of SOD and catalase. Lycopene also modified the levels of immunoregulatory cytokines (IL-1β and IL-6) favourably. The dose dependent efficacy of lycopene in the current experimental condition was also attested when exemplified morphologically through scanning electron microscopy. Conclusion From the current line of evidences, it was concluded that lycopene can impart momentous protection against experimental esophagitis by wrapping up the reactive oxygen species and through dual inhibition of the arachidonic acid pathway.

Can red yeast rice and olive extract improve lipid profile and cardiovascular risk in metabolic syndrome?: a double blind, placebo controlled randomized trial. BMC Complementary and Alternative Medicine 2015, 15:52

Background: Metabolic syndrome (MetS) comprises a spectrum of clinical phenotypes in which dyslipidemia, dysglycemia and hypertension are clustered and where all share a high level of oxidative stress and an increased risk of cardiovascular disease. This study examines the effect of a nutritional supplement combining red yeast rice and olive fruit extract on the lipid profile and on oxidative stress in a population of patients with MetS.

Methods: In a double blind placebo controlled randomized trial, 50 persons with MetS, as defined by the ATPIII criteria, received the study product or placebo for 8 weeks. The study product contained 10.82 mg of monacolins and 9.32 mg of hydroxytyrosol per capsule, and is commercialized as Cholesfytol plus. The primary outcome measure was the difference in LDL reduction between intervention and control groups. Furthermore, differences in changes of CH, HDL, ApoA1, ApoB, HbA1c and oxLDL were measured, as well as side-effects, CK elevation, changes in clinical parameters and in cardiovascular risk.

Results: In the intervention group, LDL cholesterol was lowered by 24% whereas it increased by 1% in the control group (p < 0.001). Other effects observed were a change in total cholesterol (~17% in the intervention group vs +2% in the control group, p < 0.001), apolipoprotein B (~15% vs +6%, p < 0.001), and TG (~9% vs +16%, p = 0.02). Oxidized LDL decreased by 20% vs an increase of 5% in the control group (p < 0.001). Systolic and diastolic arterial blood pressure decreased significantly by 10 mmHg (vs 0% in the control group, p = 0.001) and 7 mmHg (vs 0% in the control group, p = 0.05) respectively. One person in the intervention group, who suffered from Segawa’s syndrome, dropped out because of severe muscle ache.

Conclusions: The combination of active products in this study may be an alternative approach to statins in people who do not need, or cannot or do not want to be treated with chemical statins. Side effects, effects on oxidative stress and on glucose metabolism need to be examined more thoroughly.

Aromatherapy


Effect of the fragrance inhalation of essential oil from Asarum heterotropoides on depression-like behaviors in mice. BMC Complementary and Alternative Medicine 2015, 15:43

Background: Psychological stressors may cause affective disorders, such as depression and anxiety, by altering expressions of corticotropin releasing factor (CRF), serotonin (5-HT), and tyrosine hydroxylase (TH) in the brain. This study investigated the effects of essential oil from Asarum heterotropoides (EOAH) on depression-like behaviors and brain expressions of CRF, 5-HT, and TH in mice challenged with stress.

Methods: Male ICR mice received fragrance inhalation of EOAH (0.25, 0.5, 1.0, and 2.0 g) for 3 h in the special cage capped with a filter paper before start of the forced swimming test (FST) and tail suspension test (TST). The duration of immobility was measured for the determination of depression-like behavior in the FST and TST. The selective serotonin reuptake inhibitor fluoxetine as positive control was administered at a dose of 15 mg/kg (i.p.) 30 min before start of behavioral testing. Immunoreactivities of CRF, 5-HT, and TH in the brain were also measured using separate groups of mice subjected to the FST.

Results: EOAH at higher doses (1.0 and 2.0 g) reduced immobility time in the FST and TST. In addition, EOAH at a dose
Methods: Practice.

Practitioners across multiple domains relating to their role and of New Zealand-based naturopaths and herbal medicine examining the characteristics, perceptions and experiences response, this paper reports findings from the first national survey of New Zealand-based naturopathic and herbal medicine practitioners' perceptions and practices, to provide insights of benefit to all those practising and managing health services as well as those directing health policy in New Zealand.

Conclusion: These results provide strong evidence that EOAH effectively inhibits depression-like behavioral responses, brain CRF and TH expression increases, and brain 5-HT expression decreases in mice challenged with stress.

Naturopathy

Cottingham P, Adams J, Vempati R, Dunn J, Sibbritt D.


Background: Despite the popularity of naturopathic and herbal medicine in New Zealand there remains limited data on New Zealand-based naturopathic and herbal medicine practice. In response, this paper reports findings from the first national survey examining the characteristics, perceptions and experiences of New Zealand-based naturopaths and herbal medicine practitioners across multiple domains relating to their role and practice.

Methods: An online survey (covering 6 domains: demographics; practice characteristics; research; integrative practice; regulation and funding; contribution to national health objectives) was administered to naturopaths and herbal medicine practitioners. From a total of 338 naturopaths and herbal medicine practitioners, 107 responded providing a response rate of 32%. Data were statistically analysed using STATA

Results: A majority of the naturopaths and herbal medicine practitioners surveyed were female (91%), and aged between 45 and 54 years. Most practiced part-time (64%), with practitioner caseloads averaging 8 new clients and over 20 follow-up clients per month. Our analysis shows that researched information impacts upon and is useful for naturopaths and herbal medicine practitioners to validate their practices. However, the sources of researched information utilised by New Zealand naturopaths and herbal medicine practitioners remain variable, with many sources beyond publications in peer-reviewed journals being utilised. Most naturopathic and herbal medicine practitioners (82%) supported registration, with statutory registration being favoured (75%). Integration with conventional care was considered desirable by the majority of naturopaths and herbal medicine practitioners surveyed (85%). Naturopaths and herbal medicine practitioners feel that they contribute to several key national health objectives, including: improved nutrition (93%); increased physical activity (85%); reducing incidence and impact of CVD (79%); reducing incidence and impact of cancer (68%).

Conclusions: There is a need for greater understanding and communication between practitioners of conventional care and naturopathic and herbal medicine which could support informed, coordinated and effective health provision within the New Zealand health care system. There is a need for further in-depth research examining naturopaths and herbal medicine practitioners’ perceptions and practices, to provide insights of benefit to all those practising and managing health services as well as those directing health policy in New Zealand.

Public Health


Background: Paediatric recommendations to limit children's and adolescents' screen based media use (SBMU) to less than two hours per day appear to have gone unheeded. Given the associated adverse physical and mental health outcomes of SBMU it is understandable that concern is growing worldwide. However, because the majority of studies measuring SBMU have focused on TV viewing, computer use, video game playing, or a combination of these the true extent of total SBMU (including non-sedentary hand held devices) and time spent on specific screen activities remains relatively unknown. This study assesses the amount of time Australian children and adolescents spend on all types of screens and specific screen activities.

Methods: We administered an online instrument specifically developed to gather data on all types of SBMU and SBMU activities to 2,620 (1373 males and 1247 females) 8 to 16 year olds from 25 Australian government and non-government primary and secondary schools.

Results: We found that 45% of 8 year olds to 80% of 16 year olds exceeded the recommended <2 hours per day for SBMU. A series of hierarchical linear models demonstrated different relationships between the degree to which total SBMU and SBMU on specific activities (TV viewing, Gaming, Social Networking, and Web Use) exceeded the <2 hours recommendation in relation to sex and age.

Conclusions: Current paediatric recommendations pertaining to SBMU may no longer be tenable because screen based media are central in the everyday lives of children and adolescents. In any reappraisal of SBMU exposure times, researchers, educators and health professionals need to take cognizance of the extent to which SBMU differs across specific screen activity, sex, and age.
| Health Fund | Australian Health Management | ACA Health Benefits Fund | Geelong District Health | CUA Health (Crawfords) | Defence Health Partners | GMF Health (Goldfields Medical Fund) | GMBA (Geelong Medical) | Frank Health Fund | Health Care Insurance Limited | Health.com.au | HIC Health Insurance Fund of WA | Latrobe Health Services | MDH Midura District Hospital Fund | Nery Health Fund | Quedmedicare | Peoplecare Health Insurance | Police Benevolent Fund | Police Health Fund | Queensland Country Health | Railway and Transport | Reserve Bank Health Society | S'kites | Teachers Federation | Teachers Union Health | Transport Health | WiseFund | Australian Unity | BUFA | CRBS Health Fund | Doctors Health Fund | GHI Health (Grand United)* | Health Partners | HIF | HCP | Medibank Private | NIB |
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- **Therapy covered by Fund**: 
- **Need to Apply directly to Fund**: 
- **AHI/CDC**: are only recognizing Remedial Therapists who are accredited for this modality and are approved for ARHII Provider status under their old criteria. 
- **ARHII**: are recognizing Chinese Medicine, however, the eligibility requirements and provider number is exactly the same as Remedial Massage. See ARHII Health Fund Information for further information regarding the creation and use of the provider number.
Health Funds

ATMS is a ‘professional organisation’ within the meaning of section 10 of the Private Health Insurance Accreditation Rules 2008. This potentially allows ATMS accredited members to be recognised as approved providers by the various private health funds. Approved health fund provider status is, however, subject to each individual health fund’s requirements.

Consequently, membership of ATMS does not automatically guarantee provider status with all health funds. Please also note that several health funds do not recognise courses done substantially by distance education, or qualifications obtained overseas.

Additional requirements for recognition as a provider by health funds include:

- Clinic Address (Full Street Address must be provided – Please note that some health funds may list your clinic address on their public websites)
- Current Senior First Aid
- Current Professional Indemnity Insurance (some health funds require specific minimum cover amounts. Please refer to the individual health fund terms and conditions for further information)
- Compliance with the ATMS Continuing Education Policy
- Current National Registration (where applicable)
- Compliance with the Terms and Conditions of Provider Status with the individual health funds.

ATMS must have current evidence of your first aid and insurance on file at all times.

When you join or rejoin ATMS, or when you upgrade your qualifications, you will need to fill out the ATMS Health Fund Application and Declaration Form available on the ATMS website. Once this is received, along with any other required information for health fund eligibility assessment, details of eligible members are sent to the applicable health funds on their next available listing. The ATMS office will also forward your change of details, including clinic address details to your approved health funds on their next available list. Please note that the health funds can take up to one month to process new providers and change of details as we are only one of many health professions that they deal with.

Lapsed membership, insurance or first aid will result in a member being removed from the health funds list. As health funds change their provider eligibility requirements from time to time, upgrading qualifications may be necessary to be re-instated with some health funds.

TERMS AND CONDITIONS OF PROVIDER STATUS

Many of the Terms and Conditions of Provider Status for the individual health funds are located on the ATMS website. For the Terms and Conditions for the other health funds, it will be necessary to contact the health fund directly.

Please note that whilst there is no law or regulation requiring patient clinical notes to be taken in English, many of the major health funds do require patient clinical notes to be taken in English. Failure to do this will be a breach of the Health Funds Terms and Conditions and may result in the practitioner being removed as a provider for that health fund.

For health funds to rebate on the services of Accredited members, it is important that a proper invoice be issued to patients. The information which must be included on an invoice is also listed on the ATMS website. It is ATMS policy that only Accredited members issue their own invoice. An Accredited member must never allow another practitioner, student or staff member to use their provider details, as this constitutes health fund fraud. Misrepresenting the service(s) provided on the invoice also constitutes health fund fraud. Health fund fraud is a criminal offence which may involve a police investigation and expulsion from the ATMS Register of Members.

It is of note that the health funds require practitioners to be in private practice. Some health funds will not recognise claims where accommodation, facilities or services are provided or subsidised by another party such as a public hospital or publicly funded facility. Rebates are only claimable for the face to face consultation (not the medicines or remedies); however this does not extend to mobile work including markets, corporate or hotels. Home visits are eligible for rebates.

ONLINE OR PHONE CONSULTATIONS ARE NOT RECOGNISED FOR HEALTH FUND REBATES.

Please be aware that whilst a health fund may indicate that they provide a rebate for specific modalities, this rebate may only be claimable if the client has the appropriate level of health cover with that fund and has not exceeded any limits on how much they are eligible to claim back over a certain period of time.

Australian Health Management (AHM)

Names of eligible ATMS members will be sent to AHM each month. AHM’s eligibility requirements are listed on the ATMS website www.atms.com.au. ATMS members can check their eligibility by checking the ATMS website or by contacting the ATMS Office on 1800 456 855. Your ATMS Number will be your provider number, unless you wish to have online claiming. You will then need to contact AHM directly for the new provider number.

Australian Regional Health Group (ARHG)

This group consists of the following health funds:

- ACA Health Benefits Fund Ltd
- Cessnock District Health Benefits Fund
- CUA Health Limited
- Defence Health
- GMHBA (Including Frank Health Fund)
- GMF Health
- Health.com.au
- Health Care Insurance Limited
Add the letter that corresponds to your ATMS number please follow these steps:

1. Add the letters AT to the front of your ATMS number.
2. If your ATMS number has five digits, you need to add enough zeros to make it a five digit number (e.g. 123 becomes 00123).
3. Add the letter that corresponds to your accredited modality at the end of the provider number;
   - A ACUPUNCTURE
   - C CHINESE HERBAL MEDICINE
   - H HOMOEOPATHY
   - N NATUROPATHY
   - O AROMATHERAPY
   - W WESTERN HERBAL MEDICINE

If ATMS member 123 is accredited in Western herbal medicine, the ARHG provider number will be AT00123W.

4. If you are accredited in several modalities, you will need a different provider number for each modality (e.g. if ATMS member 123 is accredited for Western Herbal Medicine and Aromatherapy, the ARHG provider numbers are AT00123W and AT00123O).

ARHG - REMEDIAL MASSAGE AND CHINESE MASSAGE

Remedial Massage and Chinese Massage therapists who graduated after March 2002 must hold a Certificate IV or higher from a registered training organisation.

Members who are accredited for Remedial Massage or Chinese Massage, will need to use the following letters.

- M MASSAGE THERAPY
- R REMEDIAL THERAPY

The letter at the end of your provider number will depend on your qualification, not the modality in which you hold accreditation*. All members who meet the ARHG eligibility requirements, who hold a Diploma of Remedial HLT50302 or HLT50307 or a Diploma of Chinese Remedial Massage HLT50102, HLT50107 or HLT50112 will be able to use both the ‘M’ and ‘R’ letters. It is recommended to use the ‘R’ as often as possible, but as not all health funds under ARHG cover ‘Remedial Therapy’, it will be necessary to use the ‘M’ at the end of the provider number for those funds only. All other eligible Remedial Massage Therapists who do not hold the Diploma of Remedial HLT50302 or HLT50307 or a Diploma of Chinese Remedial Massage HLT50102, HLT50107 or HLT50112 are required to use the ‘M’ at the end of their provider number.

*Members accredited for Remedial Therapies and approved for ARHG for this modality under their previous criteria will continue to be recognised under Remedial Therapy and will be fine to use the ‘R’ in their provider number. Should members in this situation lapse membership, first aid or insurance etc they will be required to meet the current ARHG criteria.

**Australian Unity**

Names and details of eligible ATMS members will be sent to Australian Unity each month. ATMS members will need to contact Australian Unity on 1800 035 360 to register as a provider, after filling out the Australian Unity Application Form located on the ATMS website to activate their provider status. This only needs to happen the first time. The provider eligibility requirements for Australian Unity are located on the ATMS website www.atms.com.au. Your ATMS number can be used as your Provider Number, or you can contact Australian Unity for your Australian Unity generated Provider Number. Please note that Australian Unity requires Professional Indemnity Insurance (to at least $2 million) and Public Liability Insurance (to at least $10 million).

**BUPA** (including MBF, HBA, Health Cover Direct, AXA, NRMA, SGIO, SGIC, St Georges Health, ANZ Health and Mutual Community)

Names and details of eligible ATMS members will be sent to BUPA on a weekly basis. The provider eligibility requirements for BUPA are located on the ATMS website www.atms.com.au. The Provider eligibility requirements include an IELTS test result of an overall Band 6 or higher for TCM qualifications completed in a language other than English. BUPA will generate a Provider Number after receiving the list of eligible practitioners. BUPA advises ATMS of your Provider Number and ATMS will then advise those members directly.

**CBHS Health Fund Limited**

Names and details of eligible ATMS members will be sent to CBHS each month. The details sent to CBHS are your name, address, telephone and accredited discipline(s). These details will appear on the CBHS website. If you do not want your details to be sent to CBHS, please advise the ATMS office on 1800 456 855.
The provider eligibility requirements for CBHS are located on the ATMS website www.atms.com.au. Your ATMS number will be your Provider Number.

**Doctors Health Fund**
Names and details of eligible ATMS members will be sent to Doctors Health Fund each month. Please note that Doctors Health Fund only covers Remedial Massage. The provider eligibility requirements for Doctors Health Fund are located on the ATMS website www.atms.com.au. Your ATMS number will be your Provider Number.

**Grand United Corporate**
To register with Grand United Corporate, please apply directly to Grand United on 1800 249 966.

**HBF**
Names and details of eligible ATMS members will be sent to HBF each month. The provider eligibility requirements for HBF are located on the ATMS website www.atms.com.au. HBF is a Western Australian based health fund. HBF will only generate a provider number after they receive the first claim from your first HBF client.

**HCF**
Names and details of eligible ATMS members will be sent to HCF on a weekly basis. The provider eligibility requirements for HCF are located on the ATMS website www.atms.com.au. HCF do not issue provider numbers nor use your ATMS number as your provider number. They do however require your ATMS membership details, including your ATMS number, to be clearly indicated on all invoices and receipts issued.

**Health Partners**
Names and details of eligible ATMS members will be sent to Health Partners each month. The provider eligibility requirements for Health Partners are located on the ATMS website www.atms.com.au. Health Partners uses the same Provider number system as ARHG for certain modalities and the ATMS number or other modalities.

The provider number is based on your ATMS number with additional lettering. To work out your Health Partners provider number please follow these steps:

1. Add the letters AT to the front of your ATMS member number
2. If your ATMS number has five digits go to step 3. If it has two, three or four digits, you need to add enough zeros to the front to make it a five digit number (e.g. 123 becomes 00123).
3. Add the letter that corresponds to your accredited modality at the end of the provider number;
   - ACUPUNCTURE,
   - CHINESE HERBAL MEDICINE,
   - HOMOEOPATHY,
   - REMEDIAL MASSAGE
   - NATUROPATHY,
   - WESTERN HERBAL MEDICINE.
4. If you are accredited in several modalities, you will need a different provider number for each modality (e.g. if ATMS member 123 is accredited for Western Herbal Medicine and Aromatherapy, the provider numbers are AT00123W and AT00123O).

For all other modalities that Health Partners cover that are not listed above including Alexander Technique, Bowen Therapy, Kinesiology and Reflexology, eligible providers will need to use their ATMS number.

**Medibank Private**
Names and details of eligible ATMS members will be sent to Medibank Private on a monthly basis. The provider eligibility requirements for Medibank Private are located on the ATMS website www.atms.com.au. Medibank Private requires Clinical Records to be taken in English. Medibank Private generates Provider Numbers after receiving the list of eligible practitioners from ATMS. Medibank Private sends these provider numbers directly to ATMS. ATMS will then forward this information to the provider. Please note that Medibank has placed a restriction of up to a maximum 3 clinic addresses that will be recognised for Remedial Massage. There are no restrictions on the number of recognised clinics for other modalities.

**NIB**
Names and details of eligible ATMS members will be sent to NIB on a weekly basis. The provider eligibility requirements for NIB are located on the ATMS website www.atms.com.au. NIB does accept overseas Acupuncture and Chinese Herbal Medicine qualifications which have been assessed as equivalent to the required Australian qualification by Vetassess. Your ATMS Number will be your provider number, unless your client wishes to claim online. Your client will need to contact NIB directly or search by your surname and postcode on the NIB website www.nib.com.au for your provider number for online claiming purposes.

**HICAPS**
ATMS members who wish to activate these facilities need to register directly with HICAPS. HICAPS do not cover all health funds and modalities. Please go to www.hicaps.com.au or call 1800 805 780 for further information.
Imagine if your uniforms were designed by a fellow Practitioner, someone who knows what the uniform should perform like in an active job. Introducing 10 knots uniforms, designed by Practitioners for Practitioners.

- Style and Comfort – freedom to move, adjustable fit and superb cut.
- Durable and breathable quality fabrics. Natural Linen or Functional (Poly/Viscose).
- Ethically designed and manufactured in Australia, stock held on site, no minimum order.

Feel the difference, from AM to PM appointments you will look and feel fresh. … I designed your uniforms with a genuine desire to make a difference, aesthetically and practically.

Established in 1986, Cathay Herbal is a company that is run by practitioners who constantly work to ensure they understand and meet the needs of you, the practitioner.

All products sold by Cathay Herbal undergo rigorous development and investigation before being offered as part of their range. With one of the largest ranges of Chinese Classical formulas outside of China, they don’t just stock the popular ones. Cathay’s range is large and comprehensive.

As well as the classical Black Pill range they also have many formulas available in tablet and capsules and a range of herbal granules, liquids and plasters.

About 15 years ago Neil Skilbeck, a Chiropractor and Osteopath made a valuable discovery integrating soft tissue and bones together. This has led to our course of Musculoskeletal Therapy (MST).

We believe in integrating knowledge as it leads to very powerful solutions such as we have demonstrated through our courses. We also provide CE workshops to fill in gaps in basic training of most body therapy courses. These consist of foot corrections, nerve dynamics, limb neurology, axial and appendicular assessment and treatment and our specialty of pelvic mechanics.

BioMedica is an Australian owned company dedicated to the research, development and production of high quality, low excipient and efficacious practitioner formulations. Our products are developed by practitioners for practitioners. As a ‘Strictly Practitioner Only’ company, BioMedica is strongly dedicated to preserving and enhancing the role of the holistic practitioner.

Our products are only sold to practitioners in a clinical setting, this has been our long standing policy since our inception in 1998, and remains firmly in place to this day. We also aim to provide highly relevant technical education materials and seminars, with practical research and insights that can be immediately integrated into clinical practice.

Eagle is rightly regarded as a pioneer in the Australian ‘practitioner’ natural health sector. Established in 1966, our reputation is based on the passion and dedication of Eagle’s founder, Dr Townsend Hopkins. Maintaining his wholehearted adherence to naturopathic principles, Eagle has created a range of advanced and effective naturopathic products.

Leading Eagle formulas such as Tresos-B®, Beta A-C® Powder, Haemo-Red® Plus and Digestaid have set a standard of high quality and effectiveness that are now a part of the Australian healthcare practitioners’ vernacular.

Today, Eagle continues Dr Townsend Hopkins’ traditions by producing formulas containing vitamins, minerals, amino-acids, nutrients, herbs and homoeopathics that are trusted, reliable and efficacious.
RemStone advances results and treatment outcomes by assisting prevention, rehabilitation + maintenance - allowing the good things in life to be enjoyed. Desk bound jobs, home life activities or athletic adventures; RemStone is the universal helping hand. Developed in Australia, RemStone is a unique manual therapy offering a less invasive + more efficient treatment for pain and discomfort. RemStone accelerates remedial treatment, enhanced by unique safe + efficient fascial release stone techniques. Whilst helping the client, RemStone assists the manual therapist gain more efficient results, prevents their own potential injury and extends their longevity in the industry. If you’re a professional therapist - become a Licensed RemStone Therapist in 2014! Earn CE’s, advance your skill level, learn safe + efficient deep tissue/fascial stone release techniques and share in RemStone’s business model. We supply and support you to integrate stone massage into your business with training + career pathways, stones + equipment, marketing material - RemStone is your ready-made and hands-on solution. Courses starts soon! JUNE 2014

Terr Rosa specialised in educational massage DVDs and books. It has the largest collection of massage DVDs in Australia and the world, covering all modalities from Anatomy, Swedish Massage, Reflexology, Sports Massage to Myofascial Release and Structural Integration. We also provide the best in continuing education with workshops by international presenters including Orthopaedic Massage, Taping, Fascial Fitness and Myofascial Therapy.

Sun Herbal The No. 1 supplier of prepared Chinese herbal medicine in Australia and New Zealand. Your clinical success is our bottom line. BLACK PEARL® pills • ChinaMed® capsules • Red Peony® granules for KIDS 192 herbal formulas effective for both common and difficult to treat conditions. Sun Herbal supports you with:
• A comprehensive website
• Telephone support
• Detailed reference manuals
• Seminars & webinars
• Regular Sun Herbal ‘Extracts’ (research and case studies)
• Patient brochures & posters
• Samples & bonus offers
• Practitioner dispensing only

The ATMS Products & Services Guide will appear in every issue of JATMS

If you wish to list your company, practice, products, services or training course to appear in the June issue’s ATMS Products & Services Guide, please contact Yuri Mamistvalov on 0419 339 865.

Cost is $150 for one issue or $500 for 4 consecutive issues. Listing comprises of – Logo, 100 word profile and contact information.
The main sources of vitamin D3 in food are predominantly animal products such as butter, cheese, liver and oily fish; and are either restricted on a vegetarian diet or completely omitted in a vegan diet. Most vegan sourced vitamin D supplements are in D2 form. This form can be either sourced from plants or chemically synthesised. Although not fully elucidated, it is thought that D2 is an inferior supplemental form when compared to D3. A study conducted by Crowe et al. compared the serum vitamin D concentrations of vegetarians and vegans to their meat eating counterparts. The researchers found that individuals consuming a vegetarian or vegan diet had considerably lower serum concentrations: up to 38% lower in winter months. Both dietary intake of vitamin D, as well as the form of vitamin D consumed, are important determinants and considerations in vitamin D status and supplementation strategies.

Sustainability, purity and quality
The cholecalciferol in BioMedica’s Phyta D is vitamin D3 sourced from symbiotic plants; a mixture of fungi and algae mutually dependent on each other for survival. It is sustainably harvested from multiple sites and locations due to the natural variation in vitamin D3 content in these plants at different times and places of harvest. This harvesting process ensures sustainability along with the highest quality concentration of vitamin D.

The extraction, purification and refining of the raw material is a multistep process, utilising physical maceration and extraction via application of natural solvents. Only high-grade alcohol and water are used during the extraction, purification and concentration steps, to produce a clean, highly concentrated source of vitamin D3 that is suitable for both vegetarians and vegans. This tightly controlled process is conducted in ideal atmospheric conditions, and while these natural solvents are necessary to extract the highly concentrated D3, no traces are detected in the final product. The finished product is then packaged into a high-quality glass bottle for maximum stability and suitability for a lipid-based supplement, with the environmental benefits of recyclable glass.

Intermittent prescribing
When serum concentrations are adequate, excess vitamin D is stored within reservoirs in the body; predominantly adipose tissue and the skin. The body is able to maintain blood concentrations by liberating these stores, allowing vitamin D back into circulation. As a result, supplementation of vitamin D may occur intermittently without affecting serum concentrations, as long as the daily average intake is adequate. Several observational studies have demonstrated that intermittent supplementation, encompassing the weekly requirements for vitamin D in a single dose, is effective at meeting the body’s vitamin D requirements and maintaining healthy serum levels. This is an important clinical consideration as intermittent prescribing presents several advantages including negating issues of erratic compliance due to prohibitive cost or forgetfulness, as well as allowing for flexible dosing in particular populations such as children, pregnant women, and the elderly.

Full reference list available on request.
ADVERTORIAL

Recognise Australia’s standout primary health care professionals

By H.E.S.T. Australia

If you know an outstanding primary health care professional in your local community, now’s the time to acknowledge their efforts by nominating them for the HESTA Primary Health Care Awards.

The awards recognise the dedication and professionalism of physiotherapists, dentists, pharmacists, therapists, GPs, rehabilitation professionals, natural therapy practitioners, health educators and medical practice managers.

Nominations are open until 31 August 2015.

Primary health care services are often the first port of call for Australians when sick or injured.

HESTA CEO, Debby Blakey, encouraged people to nominate an individual or team that has made an outstanding contribution to improve health care in the community.

“These Awards recognise the exceptional contribution made by primary health care professionals in the areas of health promotion, early intervention, treatment and better management of chronic illness,” Ms Blakey said.

The HESTA Primary Health Care Awards provide an opportunity to honour these dedicated professionals and highlight the importance of an effective primary health care system.

There are three Award categories: Young Leader, Individual Distinction and Team Excellence.

Awards sponsor, ME Bank, has generously provided a prize pool of $30,000 that will be shared among the winners in each of the three categories.

Finalists will be announced in October with interstate finalists flown to Melbourne for the Awards dinner on Tuesday 10 November 2015, where the winners will be revealed.

Make a nomination — before 31 August — or learn more about the awards at hestaawards.com.au

HESTA is the super fund for health and community services with more than 800,000 members and $32 billion in assets. More people in health and community services choose HESTA for their super.

Issued by H.E.S.T. Australia Ltd ABN 66 006 818 695 AFSL No. 235249 Trustee of Health Employees Superannuation Trust Australia (HEST) ABN 64 971 749 321. Terms and conditions apply. See phcawards.com.au for details.
Thyroid disease is all too common, with little understanding of its causation. To guide effective treatment, practitioners need to discover the reasons behind illness. Knowing accurate iodine levels in patients with thyroid disease is a starting point. A testing device now available to naturopaths, the Oligoscan, is able to identify patient iodine levels in seconds.

Oligoscan is an instant in-clinic mineral analysis test which requires no tissue biopsy, urine or blood test. As well as seeing your patient’s mineral status, you also see their heavy metal burden.

Many patients with thyroid disease do not have their iodine levels checked, due to an assumption that in a country like Australia iodine deficiency is not a problem. Some doctors do order an Iodine Spot urine test, but even a normal result does not take into account factors that block iodine absorption like fluoride and chlorine (both in the water supply) and bromide, found in soft drinks, bread and also used in horticulture. An excess of these three halogens forces iodine excretion. This means that circulating iodine is blocked and forcibly excreted. A standard Spot Iodine test detects the iodine excretion as within range. This can therefore give a false impression as to the true iodine status.

A more accurate medical test to measure iodine levels is a 24-hour iodine loading urine test, which although it offers a better result, is cumbersome and costly.

The patient takes a large dose of iodine (50 mg) which then pushes against the three other halogens. The amount of iodine excretion then offers a more correct picture. Unfortunately this test is costly. The Oligoscan shows this same iodine result at a fraction of the cost and without delay.

Of the many hypothyroid and Hashimoto’s patients that I have now tested, most have identical mineral deficiency and toxicity patterns. In addition to iodine, there were substantial deficiencies of zinc, selenium and chromium, all vital for a normal endocrine function.

This has been a breakthrough for understanding the underlying causes of thyroid disease, which fall into the two clear areas of deficiency and toxicity and guide treatment that leads to recovery.

Practitioners familiar with Hair Tissue Mineral Analysis will be able to comfortably interpret Oligoscan results. Oligoscan training is also available: for upcoming seminars please go to: http://oligoscan.net.au/events.html

The sample Oligoscan result below shows Iodine and Chromium deficiency.
Supporting you to achieve outstanding results for your patients

By Sun Herbal

Case ID: GYN004 by SHU WANG
Acupuncturist/Chinese Herbalist, NSW
Female, 42, cleaner, with amenorrhea.

MAIN SIGNS AND SYMPTOMS:
She has had no period for the past 3 months. Past history of dysmenorrhea and irregular periods 18 months previously, successfully treated with CHM.

OTHER SIGNS AND SYMPTOMS:
Depressed mood, irritability, chest oppression, lower abdominal pain and distention, yellow-brown patches on the facial skin (tending to worsen in the past, when the periods are irregular), purple hued lips.

TONGUE:
Stasis speckles and purple edges. Pulse: Deep and choppy.

DIAGNOSIS:
Qi stagnation, blood stasis stopping menstruation, blockage in the Chong-Ren channels, affecting the uterus.

TREATMENT PRINCIPLE:
 Activate the blood and dispel stasis, regulate the Qi to move the blood.

TREATMENT FORMULA:
BLACK PEARL® Tao Hong Si Wu Wan (Persica, Carthamus & Dang-gui Combination BP061) a.k.a. China Med® BLOOD MOVING 2 FORMULA (Tao Hong Si Wu Wan) CM191.

DOSAGE:
50 pills (or 12 capsules), 4 times daily for 7 days.

OUTCOME:
After 7 days the abdominal pain was resolved but she felt lethargic.

TREATMENT PRINCIPLE:
Nourish the blood and promote blood production as well as to resolve blood stasis.

The formula was changed to BLACK PEARL® Si Wu Wan (Dang-gui Four Combination BP060) a.k.a. China Med® NOURISH THE BLOOD FORMULA (Si Wu Tang) CM186 50 pills (or 12 capsules), 4 times daily for 14 days

4TH WEEK:
No more abdominal distention, still feels lethargic, has breast pain and distention, poor appetite and an increased vaginal discharge.

On the sixth day the patient reported that menstrual bleeding had begun, with a heavy flow and the presence of blood clots. There was no dysmenorrhea.

She continued treatment with BLACK PEARL® Tao Hong Si Wu Wan (Persica, Carthamus & Dang-gui Combination BP061) a.k.a. China Med® BLOOD MOVING 2 FORMULA (Tao Hong Si Wu Wan) CM191, 50 pills (or 12 capsules), 4 times daily for 7 days, in order to consolidate the treatment results. She was asked to return in four weeks for reassessment. After four weeks she had another period with no abnormal signs or symptoms.

COMMENTS:
Generally the main pathodynamic underlying amenorrhea is blood stasis. However, when diagnosing and treating individual cases you should be guided by the overall signs and symptoms, as there may be associated imbalances, such as Spleen Qi deficiency or retained Damp.

In this case the primary treatment was to dispel blood stasis and alleviate pain with BLACK PEARL® Tao Hong Si Wu Wan. It should be noted that the yellow brown patches of discoloration on the facial skin, which become worse when the periods were irregular are due hormonal imbalance. The main TCM formula for normalising female hormones is Tao Hong Si Wu Wan, due to its combined actions of both nourishing as well as activating the blood.

Because this patient also showed signs of deficiency, treatment was continued with Si Wu Wan, which both nourishes the blood (main action) and activates the blood (secondary action).

Subsequent treatment focused on strengthening the Spleen and resolving Damp to regulate the Qi and dispel blood stasis with BLACK PEARL® Dang Gui Shao Yao San to strengthen the Spleen and stop pain, both in the lower abdomen and the breasts.

Finally the treatment results were consolidated by clearing away blood stasis to restore the menstrual flow with BLACK PEARL® Tao Hong Si Wu Wan.

Disclaimer: The views and opinions expressed in these advertorials are those of the authors and do not necessarily reflect the opinions of ATMS or its Directors.
Every workshop that I have taught for the past 30 years around the world has dealt with creating an appreciation for the fascial tissues that surround, support, connect, and in many ways, defend the other soft and osseous tissues of the human body.

This concern stems from a myofascial approach to structural integration that forms the foundation of my work. Like most massage therapists, I was trained at the entry level to primarily consider that my palpatory skills were focused on the musculature of the body. While I was taught that my strokes would also improve lymphatic, venous return, and neurological issues, I still found myself thinking, ‘What muscle is this, and how can I improve its tonicity?’ It wasn’t until I began my advanced structural training that I was introduced to the importance of the fascia and its integrative role with other systems.

My advanced training focused on techniques that improved the relationship between structure and function. The idea of taking the fascial tissues through a thixotropic phase change implied that these tissues were paramount in releasing muscle tension, improving both venous and lymphatic flow, reducing neurosensory excitability, and balancing structure and posture.

My experience tells me that chronic pain resides in these fascial tissues, especially in the deep fascia that surrounds the body and the epimysium that surrounds the extrinsic musculature. Over the years I have refined the foundational technique that I use to prepare the myofascial tissues for deeper and more specific work. This technique is called CORE Myofascial Spreading. It approaches the fascial tissues at a 45 degree angle and uses a minimum amount of lubrication to increase tissue temperature.

The technique is applied slowly with the broad surfaces of the palm, finger pads, or fist. This technique has allowed me to more easily ‘feel’ the improvement of thickened or adhered fascial tissues. My experience seems to suggest that if more effort is made in working in a full-body approach with these two outer layers of myofascia, an improvement in related systems is achieved and more easily maintained.

Application of any myofascial technique should take into consideration the layout of the sensory nervous system on the outermost layers of fascia. CORE Myofascial Spreading follows the primarily horizontal layout of Langer’s Lines, so that a minimum amount of nerve stimulation can be maintained during slow, but forceful strokes. This organization of stroke delivery is crucial to a balanced application of full-body sessions that promote fascial improvement.

CORE Myofascial Therapy course will be taught directly by George P. Kousaleos in Sydney in September 2015. For more information visit www.terrarosa.com.au
The structure of the iris is composed of thousands of fibres arranged in individual patterns – each one so unique that security companies use the iris for biometric identification.

One can only marvel at the design, the anatomical order and the structure and function of the complex organ we call the eye. Yet within this consistency, there is an infinite range of possible variations that identify each person’s individuality. In fact, no two eyes are the same. Some have likened the iris to DNA.

The iris has a profound range of structural possibilities and an amazing assortment of colours. The sclera (white part) can express various colours and vascular signs. The collarette (the circular frill around the pupil) can vary in position, shape and quality and the pupil and its border is subject to change in size and shape. The eye is serendipity of all that we inherit and much of what we experience on our own personal journey.

It has a reflex connection to every organ and tissue in your body by way of the nervous system. It has long been said: “the eyes are the windows of the soul”.

Every iris is unique. There are no two irises exactly alike – your right eye will differ from your left - each iris is as individual as your fingerprint.

Integrated Iridology is the study of health via an examination of the colour and structure of the iris, the sclera and the pupil.

The colour and pattern of the iris fibres can determine underlying inherent weakness, which may or may not be activated according to diet, environment and psycho-social factors.

Iridologists assess colour and fibre structure variations to determine the constitutional strength of the physical body, as well as aspects of personality, which can be influenced by conscious and unconscious emotional patterns. Iridology is not a modality. It is a screening tool used to detect individual predispositions and potential health problems at the earliest stage. This enables you an opportunity to prevent illness and maintain optimum wellness.

Integrated Iridologists believe the colour and structure of your eyes is a unique representation of the health issues of parents, grandparents and great grandparents. These issues can be physical, mental or emotional. Your individual disposition can be activated or remain dormant.

We all inherit combinations of traits from our family tree, but how much of this specifically affects you? Diet and lifestyle have a huge impact on some people, but not on others. Why are some able to get away with abusing their bodies? Which mental and emotional aspects significantly affect our physical health? And as we get older, we lose our vitality at different rates. What is your individual rate?

Going through life without this information is like taking a trip without a map. What are your chances of arriving at your desired destination? Will you get there efficiently, or end up taking many detours along the way? And how will you know where you are heading next? Iridology can take the guesswork out of a lot of these questions.

Viewing the iris as a road map or blueprint, you can discover how well you are put together, how much abuse your body can handle, where your body will tend to get sick, which organ systems are at greater risk, specific underlying reasons contributing to your symptoms and what emotional or behavioural factors are influencing these patterns.

In short, the iris can show you where you came from, where you are headed, what kind of body you have for a vehicle, and...
what type of driver you are. With this knowledge, you can more effectively approach health challenges and also identify preventive strategies that could be employed.

The iris is the sum of all your inborn characteristics, indicating your reactive capability which in turn determines your capacity for adaptation physically, mentally and emotionally.

Today, people are in need of preventative health care and less complex methods of analysing the condition of their health. Iridology provides a non-invasive, painless and economical means of looking into the body, which may be utilised in conjunction with any other system of analysis or diagnosis available.

The colours and patterns in your eyes indicate more than just health issues. For example, people with coloured spots (jewels) in their eyes tend to want to see things in writing. Those with textured gaps (flowers) prefer verbal explanations. These opposing types complement and often attract one another in relationships.

There are three primary colour groups recognised in iridology: They indicate familial traits.

**BLUE EYES**
Most often seen in blonde haired, fair complexioned people.
- Childhood ear, nose and throat complaints and various allergies
- An overactive lymphatic system, with glandular sensitivity
- Upper respiratory issues including asthma, bronchitis and sinusitis
- Hyperacidity resulting in inflammatory conditions including arthritis and rheumatics
- Hardening of arteries is common in advancing age

**BROWN EYES**
Usually in conjunction with darker hair and olive complexion.
- Circulation problems
- Digestive disorders including flatulence
- Liver congestion - often with disturbed bile production
- Glandular conditions
- Hemorrhoids and thromboses
- Variable blood sugar levels
- Women tend toward hormonal disturbances; especially thyroid and ovaries

**MIXED COLOR**
- Sluggish liver and gall bladder issues including gall stones
- Constipation or diarrhoea
- Flatulence
- Glandular conditions
- Variable blood sugar levels

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Dear Editor,

When Australian Prime Minister Tony Abbott announced his ‘no jab, no pay’ policy, and the Labor Party leader Bill Shorten declared his support for this draconian legislation, they were propelling Australia into medical fascism. Philosophical and religious exemptions to vaccinations will be quashed, and families who choose not to vaccinate their children will lose 70% of child welfare payments.

It’s a path the Nazis began when they jackbooted their way across Europe 70 years ago, vaccinating all children, with diphtheria vaccine, and conducting other medical experiments at concentration camp hellholes. Aside from war casualties, diphtheria had been the leading cause of death and disease.

After the war, the Allies vowed that such experiments should never again happen. The freedom to choose your or your children’s medical treatment was enshrined first in the Nuremberg Code, and later in the Declaration of Helsinki (1964). Though Australia has no Bill of Rights, it has an historical convention that citizens have the right to choose their medical treatment. Freedom of choice is the very foundation of traditional medicine that every member of ATMS and all our patients enjoy.

The Australian Charter of Healthcare Rights: A Guide for Healthcare Providers, published by the Australian Commission on Safety and Quality in Health Care, created by Health Ministers in 2006, states: “Participation by patients in their health care … includes informing patients and consumers of their right to refuse or withdraw consent at any time…”

So, the bilateral legislative proposal will not only breach the Nuremberg Code, the Declaration of Helsinki, and the historical conventions about medical choice, but it will also breach the UN Convention on the Rights of the Child, in this instance Articles 5, 18, 26, and 27. This is to be expected of both major political parties since they’ve been breaching this UN Convention (Article 22) by sending refugee children to prison hellholes (euphemistically called “detention centres”).

And both parties are ignoring a legal precedent established by the High Court (Rogers vs Whitaker, 1992), that medical choice about any medical intervention (and vaccination is a medical intervention) is meaningless unless the likelihood of adverse events, however long the odds of that happening may be, is explained to the patient.

This is also yet another episode in the 5000-year saga of male domination, suppression and violation of the rights of women and children, so well explored by Riane Eisler in The Chalice and the Blade.

The looming uproar is not about the pros and cons of vaccines. It’s about choice; our rights, the freedom to choose our medical treatment. Every clear thinking citizen should visit their local Federal MP, and demand continuation of our traditional rights to medical choice. Otherwise, we’re heading, once again, down a dark path.

Jesse Sleeman
Mount Barker, South Australia
Continuing education (CE) is a structured program of further education for practitioners in their professional occupations.

The ATMS CE policy is designed to ensure its practitioners regularly update their clinical skills and professional knowledge. One of the main aims of CE is to keep members abreast of current research and new developments which inform contemporary clinical practice.

The ATMS CE policy is based on the following principles:

- Easily accessible to all members, regardless of geographic location
- Members should not be given broad latitude in the selection and design of their individual learning programs
- Applicable to not only the disciplines in which a member has ATMS accreditation, but also to other practices that are relevant to clinical practice which ATMS does not accredit (e.g. Ayurveda, yoga)
- Applicable to not only clinical practice, but also to all activities associated with managing a small business (e.g. bookkeeping, advertising)
- Seminars, workshops and conferences that qualify for CE points must be of a high standard and encompass both broad based topics as well as discipline-specific topics
- Financially viable, so that costs will not inhibit participation by members, especially those in remote areas
- Relevant to the learning needs of practitioners, taking into account different learning styles and needs
- Collaborative processes between professional complementary medicine associations, teaching institutions, suppliers of therapeutic goods and devices and government agencies to offer members the widest possible choice in CE activities

- Emphasis on consultation and cooperation with ATMS members in the development and implementation of the CE program

ATMS members can gain CE points through a wide range of professional activities in accordance with the ATMS CE policy. CE activities are described in the CE policy document as well as the CE Record. These documents can be obtained from the ATMS office (telephone 1800 456 855, fax (02) 9809 7570, or email info@atms.com.au) or downloaded from the ATMS website at www.atms.com.au.

It is a mandatory requirement of ATMS membership that members accumulate 20 CE points per financial year. CE points can be gained by selecting any of the following articles, reading them carefully and critically reflecting on how the information in the article may influence your own practice and/or understanding of complementary medicine practice. You can gain one (1) CE point per article to a maximum of three (3) CE points per journal from this activity:

- Muscollino J. Upper crossed syndrome
- Harris T, Grace S, Eddey S. Adverse events from complementary therapies Part 1
- Boyle M. Could methylation be considered a cancer screening tool?
- Bonello R. The use of ENAR therapy in Australia
- Clarke A. Vegetarianism and sustainability
- Medhurst R. More research on homoeopathy
- Pagura I. Leases, what you need to know

As part of your critical reflection and analysis, answer in approximately 100 words the following questions for each of the three articles:

1. What new information did I learn from this article?
2. In what ways will this information affect my clinical prescribing/techniques and/or my understanding of complementary medicine practice?
3. In what ways has my attitude to this topic changed?

Record your answers clearly on paper for each article. Date and sign the sheets and attach to your ATMS CE Record. As a condition of membership, the CE Record must be kept in a safe place, and be produced on request from ATMS.
## Continuing Education - Calendar 2015

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<tr>
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<tr>
<td><strong>JUNE</strong></td>
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<tr>
<td>Webinar: A child’s mind - ADHD and other mental health issues</td>
<td>Stephen Eddey</td>
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<tr>
<td>Seminar: Understanding a Natural Medicine Practitioners Requirements for Clinical Practice - Massage practitioners only</td>
<td>Maggie Sands</td>
<td>Crows Nest</td>
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<td>Webinar: EBSCO</td>
<td>Cindy Slater</td>
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<td>Seminar: Myofascial Trigger Points - The Upper Body.</td>
<td>Raymond Smith</td>
<td>Sydney</td>
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<tr>
<td>Seminar: Understanding a Natural Medicine Practitioners Requirements for Clinical Practice</td>
<td>Maggie Sands</td>
<td>Newcastle</td>
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<tr>
<td>Webinar: Melanoma</td>
<td>Manuela Malaguti-Boyle</td>
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<td>Seminar: Client Care for Bodyworkers</td>
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<td>Webinar: Body Signs</td>
<td>Body signs</td>
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<td>Seminar: Treat the Pelvic Girdle</td>
<td>Laurie Fawkner</td>
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<td><strong>JULY</strong></td>
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<tr>
<td>Seminar: Fertility.</td>
<td>Ann Vlass</td>
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<td>Webinar: Stomach and Gastric Cancer.</td>
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<td>Seminar: Pregnancy Massage</td>
<td>Lynne Davidson</td>
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<td><strong>AUGUST</strong></td>
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<td>Seminar: Treatments for depression</td>
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<td>Seminar: Client Care for Bodyworkers</td>
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<td>Seminar: The 5 Critical Steps to Fixing Pain</td>
<td>Steve Lockhart</td>
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<td>Webinar - The Patient/Practitioner Interaction Skills in TCM Practice</td>
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<td>Seminar: Treat the Shoulder</td>
<td>Laurie Fawkner</td>
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<td>Webinar: Liver Cancer</td>
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<td>Seminar: Understanding Practitioner Requirements for Clinical Practice</td>
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<td><strong>SEPTEMBER</strong></td>
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<td>Webinar: Better sleep</td>
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<td>Seminar: Acupuncture in the Treatment of Foot Pain</td>
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<td>Webinar: Blood Cancers</td>
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<td><strong>OCTOBER</strong></td>
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<td>Seminar: Chronic Fatigue Syndrome</td>
<td>Stephen Eddey</td>
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<td>Seminar: Muscle Energy Techniques</td>
<td>Chris Beasley</td>
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<td>Seminar - Basics of Sports Nutrition</td>
<td>Kira Sutherland</td>
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<tr>
<td>Seminar - Basics of Sports Nutrition (day 1) &amp; Working with Athletes (day 2)</td>
<td>Kira Sutherland</td>
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<td><strong>NOVEMBER</strong></td>
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<tr>
<td>Seminar: Detox Massage</td>
<td>Lynne Davidson</td>
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The proposed seminar and webinar topics, dates and locations (for seminars) are subject to change. Please keep an eye on the ATMS website [www.atms.com.au](http://www.atms.com.au) for the latest information and to book online.
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