Erica Meloe 0:00
Hey everybody. This is Erica Meloe, and welcome to episode number 224 if you're listening to this live, hope you all had a fantastic summer. It always goes by too fast for me to be honest. This summer in particular, actually, and I know everybody sort of comes in and out with vacation. I actually was in France this summer, in August, recently, actually, I did not go to the Olympics. I went right into Paris and right up to the north in a place called doville and and also Normandy. And for those of you who are into World War Two history or not, Normandy was very, very moving. And my father actually flew B 17 bomber planes during World War Two, and it was just seeing the the images up on the beaches up there, and going into the American Cemetery was was, you know, brought tears to my eyes. And for those of you who've never been to France, obviously Paris would be the first place you would go. But the North is beautiful. Doville is amazing.

And I actually played tennis when I was up there, which is one of the reasons why I wanted to do this podcast. I used to play competitive tennis when I was younger, and I got back into it a little bit up in the north Davila is like the Lexington, Kentucky and the Hamptons of the north of France, right? And there was a lot of open space, a lot of beaches, a lot of I went to the horse races there. It was really quite amazing. Very different vacation than what I normally do, but I did play tennis, and in my homage to the US Open, I wanted to talk about a couple of things regarding people who play tennis or people who don't, because this applies to anybody who has issues in their upper extremities. So this, you know, you know we talked a lot about over the years throughout this is our number. What did I say? 224, I mean, we've had so many episodes, and there are little clinical pearls that you can take from each episode. And I know we don't all have the time to listen to the episodes in full, so that's why we like putting out these sort of shorter episodes to give you a couple clinical pearls to actually think about. And so when I got back from from France, I actually came back with a really pet stomach virus, and kind of took me out for a bit, actually, but when I recovered, I took myself to the US Open, and I went to the day matches and got really into, back into tennis. And this is one of the reasons why I wanted to talk about, talk about these two, these two sort of clinical pearls with regards to tennis players or anybody who plays an overhead sport.

So I'll just briefly explain, and then you'll go on. We'll go on to the episode. You know, how do we number one? Shoulder issues are common in many people, rowers, anybody who has an upper extremity sport, right? Baseball, tennis. But what's specific to tennis players that may be different from a rower or different from a baseball player. I will explain that in the in the in the podcast, but think about that what, what did they do, or what happens to their upper thorax and their GH their lenihumal joint that you may not see in a baseball player, because baseball players are doing a lot of this. Tennis players have a lot of you know, they're, they're, they're, they're moving differently. That's all I have to say. And then secondly, I talk about open chain versus closed chain. I'm speaking about a specific patient of mine, who is a tennis player and who, for the life of him, can't get into the open chain, it has been a difficult progression to do, literally like an open chain, bilateral, excuse me, single arm lift, where he can do push ups on the floor, no problem. And so why is that? I just wanted to explain a little bit what I think my like,

my hypothesis is, and I want you to look at that, look, think about that when you're working with anybody who's at an upper extremity condition, condition like this. So we hope you, hope you enjoy the episode. Susan and I will be live very soon, discussing, discussing more patient cases.

Erica Meloe 4:30
Everybody. This is Erica Meloe, and welcome to episode number 224, for those of you who are listening on YouTube, we really appreciate it. We're trying to do a little bit more visual especially when Susan and I get together. I know podcasting is fantastic for audio, and I listen to it all the time, but we do have a YouTube channel. So we had, in the past, broadcast all of our audio over, but now we're doing video as well. So for those of you. Need a visual. You know, it's just pop on over and Catch it. Catch it, catch a few clips. And, you know, I tend to use my hands a lot when I talk, so if you're something you're not getting, just go onto the onto our YouTube channel. It's called tough to treat. So in the intro, I talked about tennis and tennis players, and my homage the US Open this year. And years ago, I used to play competitively. I don't play competitively anymore, but as I mentioned in the intro, I recently played a bit in France, and I really got back into it, to be honest. And I'm treating a tennis player now, who I he's not. He used to be a tennis coach. He has a job here, like a sedentary job here in New York. Nobody plays a lot, and I've been treating him on and off.

The attendance has not been good because of his travel schedule. And that's another episode altogether. How do we work with patients who travel a lot? And it is, it is, you know, people are traveling more, and it's a fact of life, it's reality. So how do we actually do that? But that's another episode. Susan and I can probably do do that together. Was a leech of different, different thoughts. And so I want you to think about, when you're working with someone who has, let's say they have a shoulder shoulder problem. Okay, this particular patient I'm thinking about, he has right upper trap symptoms. He had your typical sort of Thoracic Outlet, you know, coldness into his arms, into his fingers. He also had little bit of pins and needles. Was worked up for Thoracic Outlet Syndrome imaging, nothing was found, and he had some therapy in his home country where he where he was on vacation. He's Canadian, and he really lives in New York and works here, and so the the one thing I want you to think about, it doesn't they don't have to be a tennis player, okay? But I'm just using him as an example. Clearly, he had, he had a very sort of lanky body type, a lot of hypermobile scapular winging common right? His scapula is not his driver. It would be very rare to have that as his primary, his primary driver, as we say, right, unless there was a fracture there, which there was not, and so, but I want you to think about because this is a short episode. There's a lot of compression on the dominant side between the GH and the upper thorax. Okay, your ribs, 234, I've done a lot of work with LJ Lee up in Vancouver on her thoracic ring approach. And for anybody who's not familiar with it, I would urge you to look into it. It, it's, it's an area of the body that is often, often overlooked. Okay, so his, his right glenohumeral joint, and his upper, upper, upper ribs, 234, really, not a lot of space in there. And you're like Erica. Well, how do you figure that out? Well, clearly, you're going to put your hands on them. As a matter of fact, when I got my hands up in his axilla, on his ribs, 234, I was reproducing all the symptoms down his arm.

And so, yeah, is that? Is that what I want to do? He wasn't like, he wasn't really an irritable, you know, symptomatic patient. So I felt okay with that. But the main thing is that you want to, when you're with a patient for the first time, or you're reassessing somebody, train your eye, train your hands first. Okay, get in front of a mirror. Put your hands on their GH so I put them like, literally like, for those of you who are not watching, it's hard to do it on myself, because I'm trying to go laterally. But you want to get your your your hands like almost on the joint line, and just just, just close your eyes and palpate in space. One's going to be a little bit more forward than the other. It's common, normal finding, right? Have them do a bilateral arm lift, because tennis players obviously have to lift their arm up, and we all do in life. Then close your eyes and see if you are feeling any kind of medial compression on one side, any kind of anterior translation. Once again, these are common. It's common. Then what I want you to think about is, is one side different than the other. You can open your eyes look in the mirror. Don't put your hands on the person and have them lift their bilateral arm, lift and see if you see what you felt. And it's a good way to train your eyes. And what I will tell you is that if you put your fingers up into the armpits, Susan and I talk a little bit about this on on several of our episodes, there's got to be you're going to have a harder time feeling for for the ribs, the intercostal spaces on one side more than the other. And this would require an entire course, an entire hour episode, which I'm not going to get into. But. But the main reason I wanted to bring this up is that you cannot just treat the glenohumeral joint. With this particular patient.

Okay. He had upper trap symptoms, levator arm pain. He was seen by a group practice here in New York, and all they did was rotator cuff strengthening. Like, seriously, why was his rotator cuff weak? Just because he has a shoulder problem doesn't mean his cuff is weak. They didn't take the time to assess the whole person or assess him, right? So briefly, you want to do what I said previously, put your hands on the GH see people in the interior, translation, medial translation, side to side. Stick your hands up in their armpits. Ask permission. It's a very sensitive place to be. I've had a couple people go vasovagal on me when I've done that. So really be careful and just, just palpate, palpate. Feel, have them do the arm lift. Just see if you feel anything. We're not going to name what we're feeling. We're not going to, you know, over analyze this. Okay. Just feel if you're feeling something different. Side to side. Note it down. You can make up a word. Increase compression, you know, decrease base intercostals, 2334, right? Just, just make write it down. And when you are treating the patient, because I don't want to, I wanted to, sort of, that's a brief little assessment. I mean, I could go on and on about this, but this is a short episode. The main reason I mentioned it is people forget to look at the upper thorax. They look at the GH, oh, there's a medial compression. What muscles cause medial compression? Subscap is a big one, big one, right? But if there's a connection between the upper thorax and the GH, treating the GH will not get the patient better, which is what happened to my patient, right? He came in to see me think that the GH didn't, didn't get him better, because people the prior therapists, overlooked his upper thorax. Tennis players, really common to have a lot of compression and a strong connection between the GH and the upper ribs significant. Okay, so assessing all of that is a little bit beyond this short episode, but I want you to recognize the fact that there could be an upper thoracic component to your patient's problem,

whether they're a tennis player or not.

You can certainly go in and depending on what you find, you know you need to. You know you can release some of the intercostal muscles. Their lats are a big compressor as well. But my point is, is that you cannot just treat one region of that one region. You have to treat both in the same session for the most part. Okay, if anybody has any questions on that, feel free to feel free to reach out. But I just the goal of for this little piece was to get you to recognize that it's not always the Glenn of humoral joint only okay. The second piece with this, with this particular patient, so he I actually did treat his Glenn humeral and his upper, upper upper upper ribs, 234, in the same session, I did a lot of hands on, you know, manual dynamic release. And then we ended up moving to exercise. And this is what I want to talk about, open chain versus closed chain. They need to do both. It is going to be very hard for a patient who has a true Glenn, a humeral driver

Erica Meloe 13:51
and oh and a deltoid weakness, most likely anterior deltoid, not generally cuff, mostly anterior deltoid, to do an open chain, supine arm lift. That's going to be very hard for them. Very hard. They'll start to, you know, compensate, use their pecs. They'll start to compress levator upper traps. This is exactly what this guy did, and I had a really hard time progressing him at first, and so I went in through the back door. I got him in closed chain, just because someone has a deltoid, because they're a tennis player, doesn't mean you can't get them on their hands and knees. You absolutely need to do that. They need to load the deltoid right. They need to get more further forward on their hands. So I did a lot of that, maybe a little arm lift to get some deltoid work bilaterally, and then we went into that. So that's close chain, still having a hard time with like a, like a, I had him hold a water bottle in between his hand and supine and hook lying, doing a bilateral arm lift with with a water bottle. He had a hard time with that, but he could do hands and knees. No problem. Get to get him on the wall, doing wall push ups. No problem. I felt just like I had mentioned earlier.

I put my hands on his GH, put my hands on his upper. Upper thorax, I didn't feel any compression, everything, all the all the over, activity was released. And so now we were training, so you need to release overactive muscles first, generally, and then you up train. So you down train with the release. You down train with easy exercises. And now we're up training a little bit with more active exercise. And so he was doing wall push ups, normal, narrow, sorry, normal, I'm looking at the My, my, my face here, on, on, on, zoom. So the normal, narrow and wide. You need to do that. You need to train all those spaces of support in a push up on the wall, on the plinth, on the floor. Okay. He could do all those. No problem, near zero problem. And you put him on, for example, a down dog position, zero problem, not a problem at all. It's a why? Why can't he do a supine, open chain water bottle lifted? He can do a push up on the floor. The mechanism of it's the connections between the thorax and the glenohumeral joint, and also the fact that the deltoid is significantly weak, and his overactivity in his Levator scap and upper traps really appears in an open chain supine position. And that's really obvious. And so if you're having a problem progressing somebody in an open chain, you can keep loading and loading

closed chain to a much higher degree. And don't be afraid to do that before you progress them further into open chain, because they're non optimal patterning is appearing in open chain. So what you want to do is you want to be able to down train that in easy exercises, so to speak, closed chain. As I mentioned, we did wall push ups. We did, you know, planks all in, you know, normal, narrow, wide, you know, on the wall, on the plinth, on the floor. And so we did a lot of that. And then what I also did with I had him do a lot of rotation, because clearly, tennis is a rotary sport, had him go on the wall and just do some bow and arrow. So that took his right arm into open chain, did, did a lot of that. I also had him do, which is a really cool exercise. So those of you who are on the audio, you may want to pop onto YouTube for this one, I had him put his hands on the wall like a diamond position, and just had him lift his elbows up like this and down so the hands on the wall are not moving on, just doing an air an air position here. So down with the elbows here.

So my hands are moving here, but they didn't move on. They would be on the wall. So the elbows would be this position and then this position. So more internal, external rotation. We did a lot of that on the wall, just to disassociate scapula from thoracic and scapula from humoral. That's a great one to do for people who have upper extremity, upper extremity issues. We did a lot of that. And if your patient is, you know, in better in a wider base, do you can progress to to wide, a lot of wide base. You know, it could be just a plank. It could be, it could be a push up. He ended up doing a little bit. So I had him do some one arm stuff on the wall, in addition to the bow, into the addition to the bow and arrow, he did just a sort of, you know, like a plank. And then I took his hand off so he was firing the deltoid, but it wasn't in open chain. And so it's just a different, a different what's the word? I'm looking for a different impetus or a different push to the muscle. Okay, it took out his compensations. And so especially with people who do have glenohumeral issues, or that's their driver, tennis players. Clearly, the athletes and the people who've had many injuries definitely have more than one driver, to be honest. And what I think people miss is the connections between those drivers. So when you're progressing somebody like that, you really need, because they've got such ingrained movement patterns, you're going to see the dominant strategy pickup come up in an in an exercise that is hard for them, which is obvious, right? You say, Oh, go, course, Erica, right? But it's going to, it's, it's going to prevail a little bit longer, in my experience, because of the dominant patterning that people can get away with when you're doing a lot of open chains. Easy to compensate, right? Not so easy when you're when you're doing, you're doing closed chain.

You know, I have access to Pilates, and so for those of you who do closed chain work, doing like on the reformer, the knee stretch with their hands on the bar, moving their legs back and forth on the Pilates chair, doing pikes. Great, a great way to do that. I actually had him also do some eccentrics. So I had him sit on the Cadillac. And if you can even do this with a theraband, and so you can have a theraband. Over them, so that, for those of you who are watching, it would be above me, and so it would eccentrically take the person's arms up up like this, and then they would pull down like they're doing a lat. So they eccentrically come up and pull down that, which is, I would say, that's open chain more or less, right? So that is an exercise you could do a lot if you need to think about going in the back door and using props and help when you're trying to

progress these open chain glenohumeral issues. Okay, I think that is it. I think it's one a little bit longer than I than I expected, but hopefully, hopefully you've got some clinical pearls and Susan and I will, we'll see you on the next episode. And happy fall. Falls my favorite time of the year. It's still pretty hot in New York City right now, but it is one of my one of my favorite times. So enjoy. See you on the next episode. You.