



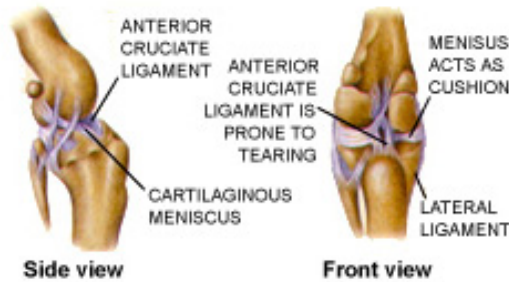
## Welcome to the Post Rehab Connection Newsletter

October 2005

International Post Rehab Month Special Extended Issue!

### Working with the ACL Post Rehab Client

The Anterior Cruciate Ligament (ACL) rupture post rehab client is the most challenging but also most rewarding of the clients for whom you will develop an exercise program. If you understand the anatomy, pathology, precautions and exercise guidelines for the ACL client – then the development of the post rehab program for other knee conditions is pretty easy.



In this article we will discuss the basic anatomy and pathology associated with the ACL post rehab client as well as exercise guidelines and progression.

The anterior cruciate ligament is the primary stabilizer of the knee during activities requiring cutting, changing direction, pivoting, etc. The ACL originates on the tibial plateau of the tibia and arises to attach within the intercondylar notch of the femur. This allows the ACL to control the anterior and rotary movement of the tibia beneath the femur. The knee menisci are found on the tibial plateau. The menisci are the most important structures in the knee. The menisci act to reduce friction, absorb shock, prevent arthritis and provide joint congruency. A tear of the meniscus may lead to severe arthritis in the knee. The menisci are 98% avascular and therefore, do not heal after tear or injury. The tear may lead to arthritic changes in the knee.



For more information visit:

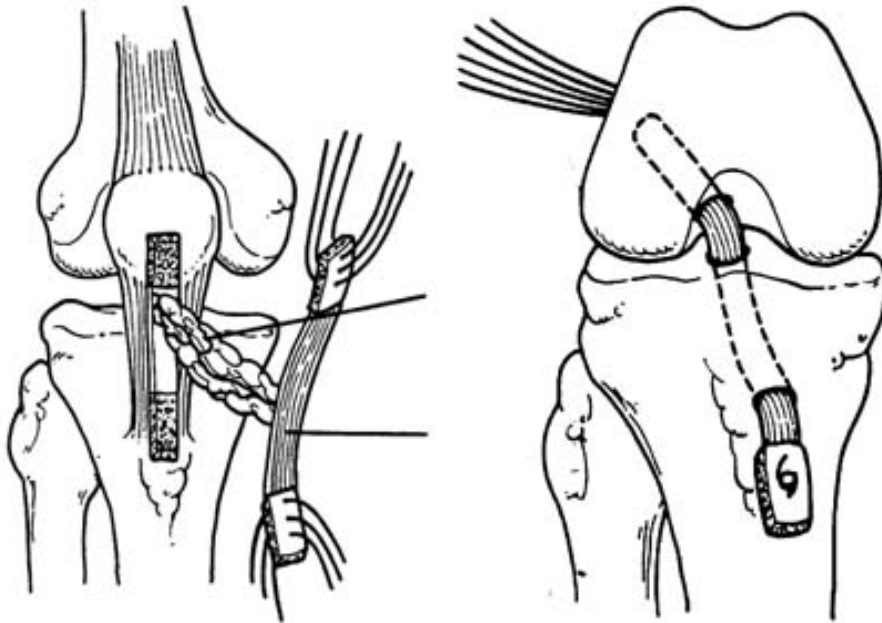
[www.postrehab.com/postrehabworks.htm](http://www.postrehab.com/postrehabworks.htm)



### Ask Dr. Mike

Happy Post Rehab Month!!! Post rehab has grown by leaps and bounds and this month we celebrate the growth of this new industry and the success of all post rehab professionals worldwide...

The ACL rupture is usually due to a rotary force applied to an extended knee. The ACL is taut when the knee is in extension, therefore, the rotary force further stretches the ligament and in situations of extremely high forces, the ligament ruptures. The rotary force may stem from a blow along the lateral or medial aspect of the knee. The client reports hearing or feeling a pop or a snap in the knee followed by severe swelling of the knee within 2-4 hours of the injury. Examination by a physician reveals severe swelling and knee instability. The physician may use a needle to draw fluid off the joint. If there is blood present in the joint fluid, then we know the ACL has ruptured. The ACL is the only vascularized structure in the joint with would cause the presence of blood upon rupture.



Patella Tendon Graft Reconstructive Surgery

Patella Tendon Graft Reconstructive Surgery

Two options are available to manage the ACL torn knee. The non-surgical option is the most conservative and used for non-athletic clients. Non-surgical management consists of an exercise program to strengthen the quadriceps and hamstrings (with emphasis on the hamstrings which will prevent anterior movement of the tibia beneath the femur); the use of a de-rotation brace with physical activity and the avoidance of activities requiring cutting, turning, pivoting and changing direction. The surgical option is used with most athletes and requires surgical reconstruction of the ACL using a piece of the patella tendon, hamstring tendon or another piece of connective tissue. The patella tendon is often used due to tensile strength. The patella tendon is 120% stronger than the ACL, therefore suitable for use when reconstructing the ACL in the athletic client.

The post-surgical management is vitally important to the restoration of knee function. Physical therapy should begin immediately with emphasis on eliminating inflammation/swelling; regaining full range of motion; increasing overall leg strength and joint stability while protecting the new ACL graft. Swelling is common following any knee surgery. The swelling will limit ROM; inhibit muscle firing of the quadriceps and may possibly lead to patello-femoral syndrome (PFS). The development of PFS in the ACL client is due to the weakness of the vastus medialis caused by the inhibition of the quadriceps. The weakness of the medialis will cause the patella to tracking laterally thus facilitating the developing of PFS. Swelling must be addressed in all knee disorders to achieve significant results with a post rehab program. Refer those clients with significant swelling back to their physician or physical therapist for further treatment to control swelling.

We offered the first certification in 1996 and since we have witnessed the acceptance of "post rehab fitness" by medical professionals, insurance carriers and the public. I never thought the tremendous growth and acceptance was possible but it is here. We find our MES', MEPD's and PRCS' working in hospitals, sportmedicine centers, physical therapy clinics, chiropractic offices, hospital based fitness programs, corporate fitness centers and health clubs.

This month, October 2005, is international post rehab month. To celebrate, we are offering our international acclaimed "PostRehabWorks Package" to post rehab professional worldwide in our effort to support post rehab professionals; assist you to better service your clients; communicate with medical professionals and develop safe and effective post rehab programming.

I would like to take a moment to remind all post rehab professionals of the scope of practice and post rehab red flags. Post rehab is the development and implementation of fitness programming for clients post rehab conditions and special populations. Post rehab doesn't purport to provide any aspect of medical treatment of the client's condition. The post rehab program may provide these services, which are part of the post rehab scope of practice:

1. Scope of Practice
2. Fitness Assessments
3. Strength Training
4. Flexibility Training
5. Cardiovascular Training
6. Functional Conditioning
7. Aquatic Fitness Training
8. Weight Reduction Programming
9. Hypertension/Diabetes Training
10. Spinal Stabilization Training

When working with post rehab clients, use these red flags as indicators the client may need referral to a medical professional and/or modification of the exercise program:

1. Red Flags
2. Radiating pain
3. Numbness/Tingling
4. Loss of Range of Motion
5. Loss of Function
6. Swelling
7. Open Wounds
8. Night Pain
9. Chest Pain/Shortness of Breath

The ACL client may begin post rehab after discharge from physical therapy if he or she meets the following post rehab criteria (a set of post rehab criteria is available for all the conditions reviewed in our courses and protocols):

1. No Open Wounds
2. Full Knee ROM
3. Good Patella Mobility
4. Full Weight Bearing Independently
5. Possess a De-rotation Brace if Prescribed by the Operating Physician
6. At least 12 weeks Post-Operative
7. Minimal Swelling in the Knee
8. Medical Clearance from Operating Physician and Physical Therapist

All post rehab protocols should have a post rehab criteria. The criteria allows the post rehab professional to identify the inappropriate client; the client that needs further medical care or will be made worse by a post rehab program.

On assessment, examine knee ROM, knee muscle strength (all muscles of the knee and hip region), knee function (use Lysholm's Scale) and swelling with the ACL client. A thorough assessment is essential in developing a safe and effective post rehab program for the ACL client. The essential assessment components are:

1. Quad Strength
2. Hamstring Strength
3. Lateral Step Up Function
4. Leg Press Strength
5. Quad Bulk
6. Knee ROM

Once the assessment is complete, begin the exercise program. The goals for the ACL post rehab program are:

1. Increase Knee ROM
2. Increase Quadriceps and Hamstring Strength
3. Protect the ACL Graft
4. Increase Functional Capacity
5. Return to Pre-injury Status

Begin with activities to increase quadriceps and hamstring strength as well as overall leg strength. Overall leg strength is a vitally important concept for all post rehab knee clients. Overall leg strength is the ability to support, control and move the weight of the body. In the situation with an athlete, this amount of weight may be as high as three times the bodyweight. For a 180lbs athlete that means the ability to dynamically lift 540 lbs. To increase overall leg strength, we strengthen all the muscles of the lower extremity. Exercises to strengthen all the lower extremity muscles are included in the post rehab program. These include:

[Click image for sample video >>](#)

I feel its important to review the scope of practice and red flags as we begin the celebration of international post rehab month. With the rapid growth, post rehab professionals must keep in mind the scope of practice to maintain high standards and to avoid moving into inappropriate arenas beyond the scope of post rehab.

I wish you all the very best and applaud your great contributions to the health, wellness and function of so many post rehab clients worldwide. Please take advantage of our post rehab tips and other free promotions during "Post Rehab Month". Please email us with a description of your post rehab setting and the types of clients with whom you work. Each post rehab professional that sends an email will receive a free copy of "101 Post Rehab Tips". Follow the link below to tell us your post rehab story.

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### Member Spotlight

for October 2005

### Blaise Eagleheart, MES



This month our member spotlight with introduce you to a dynamic gentleman who has made an amazing journey through pain and now recovery. Blaise Eagleheart, MES of Victoria, BC Canada recently underwent the Birmingham Hip Resurfacing procedure in India in March of this year. I asked Blaise to share his story with our post rehab professionals all over the world. When I received his story via email, I was fascinated and amazed. I learned so much reading this story. I know you will find it amazing as well as see many of your clients in the story.

#### Brief history of my condition

**Quadriceps**

Leg Press



Leg Extension



Standing Terminal Knee Extension



**Hamstrings**

Leg Curls



Leg Press



**Gluteals**

Leg Press



Hip Abduction



The nightmare began in March, 1993. There was no warning. I bent over to move a small (pumpkin sized) rock in the garden. When I stood up—wham!!!—a searing pain shot through both hip joints and my pelvis was locked into an extreme anterior position, creating an extreme lordosis. Note: The week before this occurred I was doing my martial art workout in the park, and all movement patterns were normal.

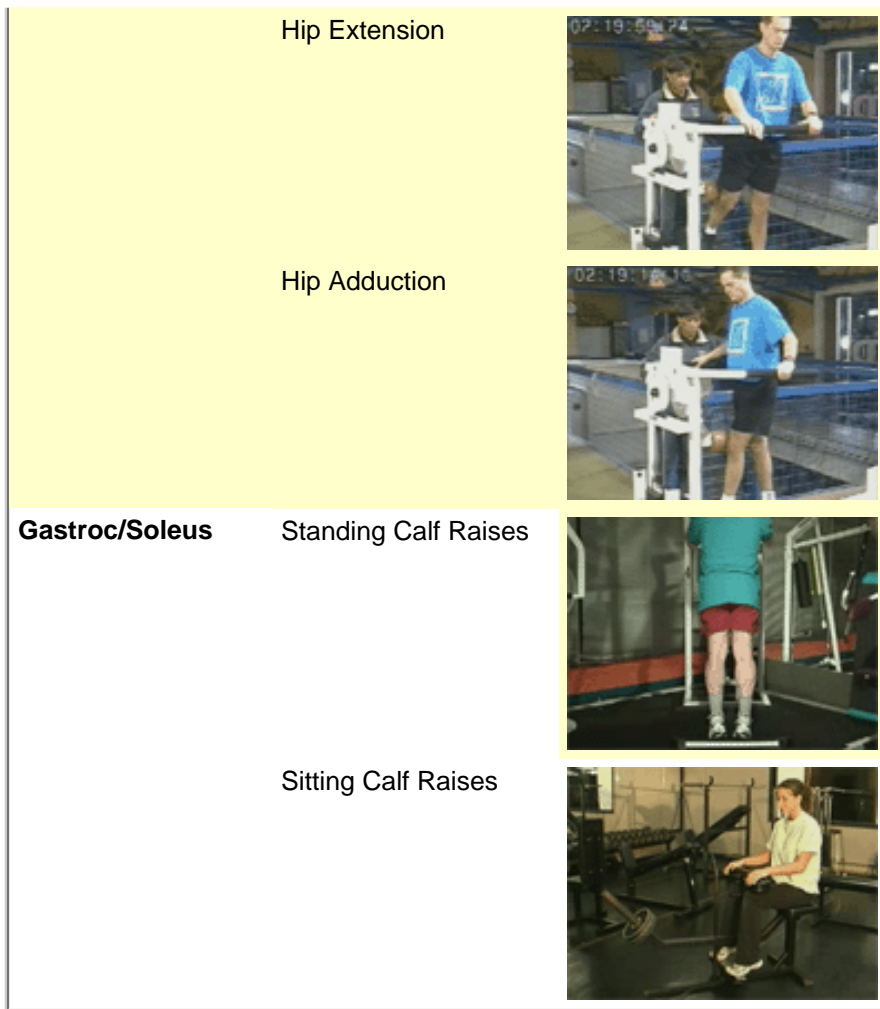
From 1993—2000 sleep was non-existent. I was up every hour, walking around until the pain subsided. I could not work, as I was not able to stand in one place for too long, bend over to pick up or carry any object, or sit for more than 15 minutes. I was OK as long as I kept moving.

From 1993—1995 I worked on my own, trying to increase my function and decrease the pain. I also went to a chiropractor 2X/wk from 1993—1995, then 1X/wk from 1996—2005 (to present day). He was the major reason I was able to function the way I did for such a long time. I would stretch and build muscle patterns and he would adjust my pelvis and spine. In the beginning I was locked really tight between my pelvis and hips. When I walked, my pelvis rotated on my lower spine, my thoracic spine went tighter into extension and my shoulder went up in order to take the stress out of my lower back and hips. My chiropractor took x-rays and found that I was born with a genetic condition called, hip dysplasia.



Blaise Eagleheart; Age 54  
X-Rays taken December 2004  
Bilateral osteoarthritis since 1993

I saw an orthopedic surgeon in 1995. He told me that I had bilateral osteoarthritis and that I needed both hips replaced. He told me that I was too young—45 yrs—to have them done and said that “you can have the quality of movement now or later, the choice is yours.” This was the ONLY choice I was given. I held off making any choices, feeling like I could beat this condition and regain my movements without such invasive surgery as a THR. The prospect of having the THR only last me 10+ years before needing another, didn’t appeal to me either. The movement limitations and restrictions that come with the THR also



These exercises form the foundation for the ACL post rehab program. As the client progresses, the exercise are modified to increase intensity. Repetitions are increased, as well as resistance and the exercises become more challenging. The goal is to develop a program that will improve the client's function as well as overall leg strength to return to sports.

Precautions to observe with the ACL post rehab program include:

1. Avoid full open chain terminal knee extension.
2. Avoid cutting, pivoting, turning activities without the use of a de-rotation brace if the operating physician has prescribed the brace.
3. Watch for signs of Patello-Femoral Syndrome (anterior knee pain).
4. Watch for increased swelling, pain or client complaints of knee instability.

The keys to a positive outcome with the post rehab ACL client are summarized below:

1. Avoid full open chain terminal knee extension.
2. Used closed chain activities to reduce shear forces on the ACL graft.
3. 4-6 months is required for the new graft to reach full maturity for return to full activity.
4. Use the hop test and/or Lysholm's Scale to determine client progression and return to sports.

steered me away from having it done. He told me that my function would slowly get worse as time went by.

In 1998 I joined the Victoria YM/YWCA and worked out three hours a day, Monday—Friday, doing active stretching movements and resistance training. The resistance training worked best for me. The more stress I put into my hip joints—through doing leg presses, squats, leg curls, leg extensions, dead lifts, good mornings—the more the function improved. The harder I made my workouts the faster I made progress. I also did intense hikes up the mountain as often as possible on the weekends. The chiropractic adjustments were getting easier and I started to sleep longer periods of time—anywhere between 3—6 hours-- before I had to get up and move. I also used acupuncture, shiatsu and massage to help improve movement patterns. I did not take any pain killers at any time. I wanted to work with the pain and to feel what was happening in my hips and lower back. I found that the caffeine in coffee was a strong natural pain killer for me. A coffee at the end of my day significantly reduced the pain. I also used a product called Regenerex, which was a mixture of MSM, Glucosamine, Calcium, Magnesium, and Baswelia Extract. I kept my diet simple and as natural as possible.

In 1999 I started the Natural Movement Centre and contracted to the Victoria YM/YWCA as a Personal Trainer. In August 2001 I became a Medical Exercise Specialist and developed an Integrated Movement and Post Rehabilitation Program at the Y. I developed the program at the Y mainly for convenience; with the pain level being so high, it was much easier for me to focus on being in one place. I worked with 6—9 clients a day—1 hr. sessions—five days/wk.

In August 2004 a member of the Y was going to India to have his hip resurfaced and he wanted me to train him when he came back. Three weeks later he walked into the Y, walking normally. I asked him what the doctor said. "In three weeks I can do whatever I want; there is no rehab, no restrictions in movement patters and no limitations, either." It seemed too good to be true. I trained him for a month and was impressed with what I saw him do and from what he told me of his experience of going to India for this procedure. He gave me the email address for Dr. Bose in India. I sent him my X-rays and he replied in less than 24 hrs., saying that I was a candidate for bilateral Birmingham Hip Resurfacing—BHR. He told me that I could have the operations in three weeks. I told him that I could come in March, 2005. He confirmed the dates and I was on my

The ACL Post Rehab Flowchart and Protocol are available by following the link below. These protocols are reviewed in our MES and Essentials of Post Rehab Fitness courses. The new PREPS manual has this post rehab protocol as well as 61 others available for purchase. Please email me with your questions regarding your ACL clients.

[ACL Flowchart and Protocol](#) >>

[Knee Functional Assessment \(Lysholm's Scale\)](#) >>

## Understanding Joint Receptors

Proprioception, balance, muscle recruitment, pain, coordination and movement are all influenced by joint receptors. The importance of joint receptors is sometimes misunderstood. Joint receptors are found in cartilage, tendons, ligaments and joint capsules around the joint. Joint receptors are stimulated by changes in the tension of the tissue surrounding them. These structures are very delicate and are easily damaged with joint injury. Barry Wyke, MD completed much of the initial research into joint receptors. Joint receptors are sometimes called mechanoreceptors. By age 65, 50% of our joint receptors are lost.

Lets take a second to understand the importance of joint receptors. Close your eyes and extend your arms out to the side away from your body. The same procedure used in sobriety testing. Now touch your right index finger to your nose. If you have your eyes closed, how are you able to know where your nose is and more importantly, how are you able to avoid punching yourself in the nose? What regulated the speed and direction of your hand? JOINT RECEPTORS DID!!!

There are four classifications of joints: type I, II, III and IV. You may have heard of these referred to as Pacinian corpuscles or Riffini receptors. Each category of receptor performs a different function and/or requires a unique form of stimulation. The golgi tendon organ and muscle spindle are also joint receptors but are not usually included in the classification process mentioned above. An important note regarding joint receptors; some joints in the body have more joint receptors than others. As an example, there are more joint receptors in the hand than the hip. Cats have such great balance due to a high concentration of joint receptors throughout their limbs and spine.

The type I mechanoreceptors are slow adapting, are stimulated by small changes in the surrounding synovial joint capsule, light pressure and slow joint movements. These receptors are found in the cervical and lumbar spines and all joints of the body. Type I mechanoreceptors usually are linked to and influence type I muscle fiber. This is particularly important in the cervical region where these receptors are responsible for postural awareness. These receptors detect tension in the joint capsule at the beginning and end of the range of motion. Type I receptors are both static (postural) and dynamic (small movements).

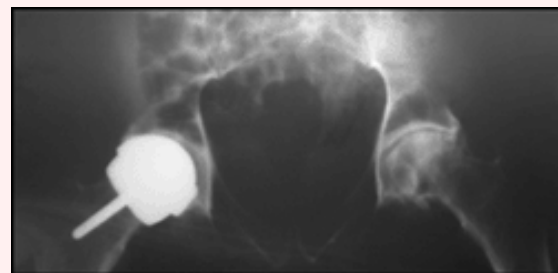
Type II receptors are faster adapting than Type I receptors. They also respond to light touch and are found distributed throughout the joints of the body. The receptors respond to faster movement and send their signal to the brain via medium-sized nerve fibers. Type II receptors are dynamic mechanoreceptors. These receptors are very important for pain inhibition and pain management.

Type III receptors are fast adapting and send their transmissions to the brain via large-sized nerve fibers. Type III receptors are found in ligaments. These receptors have a high stimulus threshold: therefore, these receptors only fire at the end of the joint range of motion.

way.

## The reasons I chose to go to India:

1. My friend's personal experience;
2. DR. Bose's skillful reputation as a orthopedic surgeon and the fact that he has done over 360 of these operations;
3. The surgery is not invasive and there is no bruising, no blood transfusion needed for one hip resurfacing, only a neat 5" scar, no muscle tissue cut;
4. Quick surgery dates—one month;
5. Cost--\$5800 US per hip, included all hospital costs;
6. Quick recovery time—5.5 weeks post surgery second hip I was back at work in gym.



Blaise Eagleheart  
X-Ray taken in India, March 2005

I had my left hip done on March 9th and the other on the 14th. On the 10th I was weight bearing in the morning and walking with a walker—a few times around my room—in the afternoon. **(I had two physiotherapy sessions a day—mid-morning and mid-afternoon. I was given these seven progressive exercises to do in supine position and one sitting up : ankle pumps; hip flexion with knee flexion; straight leg hip abduction; quadriceps contraction—press towel into bed; external hip rotation; butt squeezes; sit on side of bed and do single leg extension.)** On the 11th I was walking a longer distance outside my room and walking with crutches that afternoon. On the 12th I was walking with the crutches in the morning and walking up and down stairs with my crutches in the afternoon. On the 13th I was walking a flight of stairs with the crutches in the morning and without them in the afternoon. On the 14th I had my right hip done. The same time line was followed. On the 19th I left the hospital for the resort, where I continued my recovery until I came back to Victoria, BC Canada on April 1.

Type IV receptors send only one sensation to the brain. The sensation is pain. Pain, interestingly enough, is a subjective interpretation of neural stimuli. Type IV receptors are called nociceptors. These receptors are found throughout the body in joint capsules, articular fat pads and ligaments. Type IV receptors are stimulated when the surrounding tissue is abnormally deformed; there is a high concentration of chemical irritant or elevated tissue temperature. Chemical irritants such as prostaglandins, histamine, potassium and lactic acid stimulate the type IV receptors. The type IV receptors conduct their impulses to the brain along small diameter nerve fibers.

All joint receptors send their signals to the brain, and in some instances to the muscles surrounding the joint via nerve fibers. These nerves fibers are of varying sizes and rates of nerve transmission. This is important for pain management. Medium and large diameter nerve fibers transmit impulses from type II and III receptors. Smaller diameter fibers conduct impulses from type IV receptors. Impulses that are sent along larger size fibers nerve fibers will arrive at the brain faster than those impulses transmitted along smaller sized fibers. Larger fibers conduct up to 33% faster than their smaller counterparts. Stimulating type II and III receptors will reduce acute and chronic pain.

Rhythmic, slow, steady movements such as rocking in a chair or slow controlled trunk/leg rotation in the supine position are great activities for reducing low back pain. These activities stimulate type II and III receptors, thereby sending signals of movement to the brain. These sensations reach the brain before the pain signals arrive thereby reducing the sensation of pain.

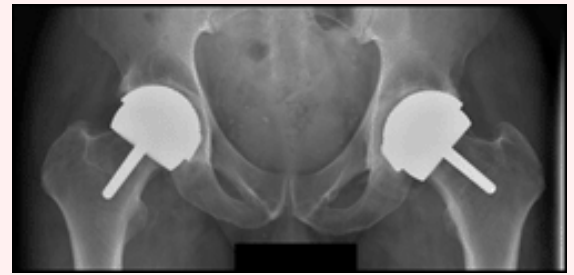
Understanding the importance and nature of joint receptors is crucial in the development of post rehab programs for clients with chronic low back and joint pain.

## Development of the Birmingham Hip Resurfacing—BHR Member Spotlight - Blaise Eagleheart

The first resurfacing arthroplasty was performed by Sir John Charnley in 1951 using Teflon/Teflon bearings. Rapid wear of the material occurred and this problem was to plague subsequent resurfacing arthroplasty attempts for the next 40 years. Resurfacing hip arthroplasty using a polyethylene cup and a metal femoral component gained popularity during the 1970's and by 1978 several systems were in clinical use. By 1982, however, reports of high failure rates resulted in the procedure being abandoned by most surgeons.

The traditional treatment of total hip replacement, though reasonably successful in elderly relatively inactive patients, offers unacceptably poor long term outcomes for young, active patients often with a saga of multiple revisions and associated complications. Metal/Metal hip resurfacing is gaining popularity as a treatment method for the young active patient with hip arthritis.

Dr. Derek McMinn and Dr. Ronan Treacy at the Royal Orthopedic and Nuffield Hospitals, Birmingham, UK, have been working on metal/metal hip resurfacing devices since 1989. The first implantation was in February 1991. In the first three years a pilot study identified optimum fixation as hydroxyapatite coated uncemented cups and cemented femoral components. From March 1994 hybrid fixed components have been used. These implants have generally been satisfactory with respect to fixation but high wear of the bearing, metallosis and osteolysis have been seen with some components inserted during 1996, a period during which the metal microstructure was altered by changes in the manufacturing process.



Blaise Eagleheart  
X-Ray April 5, 2005



Blaise Eagleheart  
Post Operation, March, 2005

I used the crutches until April 8th in order to pattern in my walking gait in a balanced manner. On the morning of the 8th I put my crutches away for good. On April 16th I went for a hike in the woods, up and down very uneven terrain. During the week of April 18—22 (5.5 weeks after my second hip operation) I worked with 11 clients at the Y. Each week thereafter I increased my hours in the gym area.

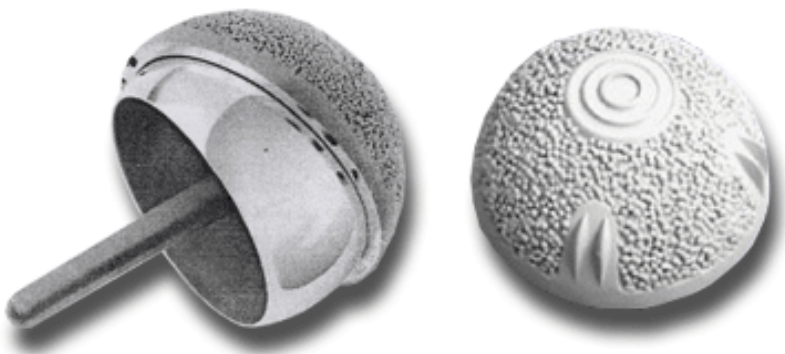
I was ecstatic with the new, pain-free movements I was experiencing for the first time in 12 years. **(Before I left for India I was only able to abduct my left hip 10 degrees and my right hip 15 degrees. Six weeks post op 2nd hip operation I went to a friend's swimming pool was able to—while being assisted by my friend and the water--abduct each hip to almost 90 degrees. Once the hip joints were free of restrictions and limitations, the muscles responded quickly and ROM and flexibility improved without any effort!!!)**

The Birmingham Hip Resurfacing (BHR) arthroplasty (Midland Medical Technologies Ltd, Birmingham, (UK) became available in July 1997. It incorporated favorable design features gleaned from experience with 500 metal-on-metal resurfacings of a variety of designs. In addition, cast-in beads were used on the acetabular cup's outer surface. Since 1997 there have been no alterations to the design or manufacture of the components. The current design is a high-carbon cast chrome-cobalt device with a stemmed spherical component designed for cemented fixation and a hydroxyapatite porous-coated acetabular component for uncemented press-fit fixation.

**(Hydroxyapatite on a porous surface has the advantage of encouraging early bone growth. When the hydroxyapatite disappears, then enduring biological fixation continues with bone ingrowth in the porous network).**

Since 1997 there have been thousands of successful BHR operations performed in over 15 countries.

### Birmingham Hip Resurfacing Components:



The BHR is a high-carbon cast chrome-cobalt device with a stemmed spherical component designed for cemented fixation, and a hydroxyapatite porous coated acetabular component for uncemented press-fit fixation.

### Blaise Eagleheart - Before & After

Pictures with grey shorts were taken March 1, 2005 (before) and pictures with blue shorts were taken the end of May, 2005 (after):



By the middle of April, I was feeling very depressed. My new found freedom to move was overwhelming. I had spent 12 years in a pain-filled hell, planning all my interactive movements based on how much pain was going to come after the movement stopped. One hour of pleasure often brought me 6 hrs to days of pain. I built a protective and rigid box around me and structured and controlled my interactive world based on the limitations and restrictions of that box.

When I had both hips resurfaced, that pain initiated box was instantaneously eliminated and I was given the absolute freedom to move. That amount of freedom was too much. I had a very hard time breaking free from those secured mental and emotional restrictions that I had imposed on myself in order to avoid any further pain during those twelve years. As long as I was contained by the box, I could function during my day. For the most part I was living in a reactive world inside the very small box, not a proactive, creative world that existed outside the box.

The femoral head of Blaise's left hip is readied for cemented fixation of the stemmed spherical component. The bone is in great shape.



Creating spontaneous, fun-filled experiences with family and friends became less and less the focus and spending more time isolated away from them and depressed myself further and further. I was totally contained by the box. I didn't know of anything else. (It was like the story of the baby elephant that was chained to a stake in the ground from a very early age. As the elephant grew older it was conditioned not to move very far as long as it had the chain around its leg.)

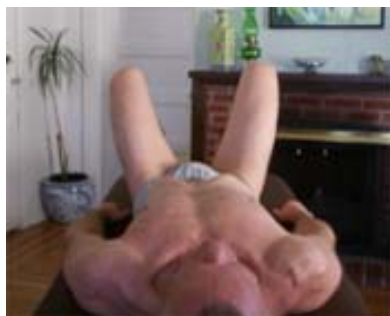
Shortly after I arrived home from India at the beginning of April, I recognized that I was frequently experiencing bouts of deep depression. I slowly and systematically set out to create more spontaneous moments of creative movement in my internal mentally framed and emotionally secured box. There were many big waves of depression and also of excitement from April until the first week in August. By the second week in August I was feeling much more alive and realized I was coming out of the depressed state. By the third week I was feeling better mentally and emotionally about my new ability to move, and



The lordotic curve went from 4.75" to 2" and I grew ¾"



Note how relaxed the Upper Back/Neck area becomes



Note how relaxed the chest/shoulders becomes



Notice the stress differential in the upper traps/neck

the unlimited ways I could now express it. I no longer felt the restrictions and limitations that once shaped and controlled every move that I made.

***"Even though the physical body was free to move after the operations to eliminate the pain and increase the function, the integrated mental and emotional components (that had wired and imprinted the circuits of my experiential brain matrix for those 12 painful years) had to go through their own releasing journey, and in their own time. The spontaneous, frequent, reoccurring depressive states I went through allowed me to create and integrate new experiential mental and emotional patterns. These new integrated patterns allowed me to free myself of the old habitual patterns of restrictive and limited movements that created and defined the box of pain I lived in. I aligned to the new movement patterns without working very hard physically, after realizing that my body's movements (or lack of) were determined by my thoughts and my emotional bonding to those thoughts. I now feel that my mind and emotions are now aligned and integrated with the creative expression of my new body."***

Feel free to contact Blaise at [nmc@ii.ca](mailto:nmc@ii.ca) for more information on the procedure. I would like to thank Blaise for his courage in sharing his story and his perseverance in healing himself.

#### Certifications

 [Post Rehab Conditioning Specialist](#)

 [Medical Exercise Specialist](#)

 [Medical Exercise Program Director](#)

 [Certification Renewal](#)

#### Current List of Available Workshops:



**Medical Exercise Specialist (MES)**

- Workshop and Certification

Toronto, Canada

November 24-27, 2005

**International Post Rehab Month Special Offer**



AAHFRP is celebrating the advances in post rehab fitness in the month of October. Post Rehab has grown tremendously since we offered the first post rehab course in 1994. More than 10,000 post rehab professionals have taken our course worldwide and we would like to celebrate the development of this new and exciting specialty in the fitness industry.

During the month of October we are offering post rehab professionals around the globe the opportunity to become a "**Medical Exercise Specialist!**" As well as obtaining the MES certification, members will also receive the only standardized post rehab protocols world wide, plus a one year membership to Postrehab.com - the only website totally dedicated to the advancement and education of post rehab professionals. This offer runs until Oct 31, 2005. [Click here](#) for more details.