PORTFOLIO

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Nescot
Epsom's college of further and higher education

Msc

ICOM EDUCATIONAL

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REFLECTIVE JOURNALS

LONG REFLECTIONS

PORTFOLIO'S INTRODUCTION

Who I am

I introduce myself: my name is Federica Terzi and I have been studying osteopathy since four years. I am 24 years old and I'm the typical younger girl who loves sport, animals, stars, music, disco, studying, sun, friends, summer, travelling, sea, etc. But first things first.

My scholastic career started when I was two and a half years old. I wore my first graduated hat when I finished my last year at daycare. So, in short, my fate had already been decided.

I frequented scientific sporty high school when I was fourteen and I'm attending the fourth year of the International College of the Osteopathic Medicine (ICOM) near Milan now. Apart from the study, I have been doing some works since I was sixteen. I tried being waitressing, babysitting, tutoring, a hostess, a salesgirl and worked in a perfumery, in a ice cream parlour, in a restaurant and in a cafeteria. Moreover, I'm practicing osteopathic training in ICOM Clinic at the moment.

I consider myself a smiley, joyful, friendly and energetic girl. I have always made friends in every place or journey and in every new experience; I have never been ashamed of nothing, especially when I was a child.

I am an animal lovers, but I'm not vegetarian. I ran away from my mom during a trip to the zoo when I was four and she found me some hours later in the boars' fence. Obviously, I got away more other times to watch or pet some animal and my mom has never more brought me to the zoo. Actually I have a dog, which name is Mya Pepita, and she is absolutely my second heart.
I'm also an extremely sporty girl. I started practising swimming when I was less than one year old and I stopped it at the age of ten because I had to choose between swimming and volleyball. Indeed, I also began playing volleyball when I was eight and I reluctantly gave up it two years ago because of a slap lesion in the right shoulder. However, I'm actually going to the gym.

As I written before, I'm studying to become an osteopath; but it's very interesting the reason for which I took this path. I got injured many times during my childhood and adolescence, especially when I played volleyball, and I always went to my physiotherapist. I saw a lot of anatomical posters and model in his medical study; furthermore he always explained me the anatomy and showed me (on models) what I had damaged. In this way, I started to be interested in manual therapy field and I chose osteopathy after the high school.

I couldn't be more satisfied for the choice I've done. I love this science because it studies the all human body and relates all the body systems. The most important and fascinating thing is that osteopathy doesn't treat the symptom but it concentrates itself on finding the cause which provoke that symptom. I mean, the pain is the consequence of something which doesn't work in the right way; but in most cases the conventional medicine operates just on pain and not on the cause. To me, people who will feel better with my osteopathic treatments, will be my biggest own satisfaction (hoping there will be).

For now, I'm think to studying and learning more and more at ICOM although it's difficult and sometimes exhausting keeping up with all my jobs, tests, extra lessons and other obligations.

I still do not know what kind of osteopath I would like to become. I wouldn't like to specialise in a single branch of osteopathy, although I would like to work with children. Surely one thing I will focus on will be the collaboration with other medical figures and other professionals in order to have a complete view of each patient at 360°.

In this picture I'm doing a fascial technique on the mediastinum. One hand is placed anteriorly on the sternum and the other is under the thoracic spine.

After graduation

I really don't know what I will do after graduating. Five important years have passed, intense and full of memories and meaning. From the fourth to the fifth academic year I have changed many ideas and I believe that I will continue to change them. But I also think that on the one hand it is right. For example, last year I thought I would like to work with children. However during this fifth year, we had the opportunity to do the pediatric clinical internship and I realized that I would not want to take this path at the moment. On the other hand, we also investigated the treatment of pregnant women during the course of Visceral Osteopathy and I was very fascinated and passionate about it. I have already tried to look for advanced courses to attend.

I have so many ideas and projects in mind. I wouldn't want to focus on a single workplace because I think it's not worth it. I'd like to try to find work in other Italian cities and move from Milan. I would like to take a course on the treatment of pregnant women and maybe look for collaborations with midwives. I would like to join some big company and work as a corporate osteopath. Finally, I would like to join some association to work as a volunteer osteopath in Italy or abroad.

As I said before, there are so many projects, but before putting them into practice, I have to think about myself. Unfortunately, this last academic year has been concomitant with heavy and important personal problems that I continue to struggle against. I am proud of me for having completed this journey, although with my times longer than my classmates, and despite my mental fatigue. I quote section D10 of the Osteopathic Practice Standards "Ensure that any problems with
your own health do not affect your patients" to say with certainty that in order to make my patients feel good, I must first be fine. So now I will focus a lot on my well-being.

Moreover, after these five years, I can say that I am sure I want to do this job, to want to contribute to the well-being of other people so that I remain in people's hearts. I am personally realizing what it means to hope that someone will help you feel better, and I would like to be the hope of someone else in future.

In conclusion, after finishing this beautiful chapter of my life, I don't know what kind of osteopath I want to be, but I know I want to be a THERAPIST.

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Thankful

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Place and Date Signature (legible)

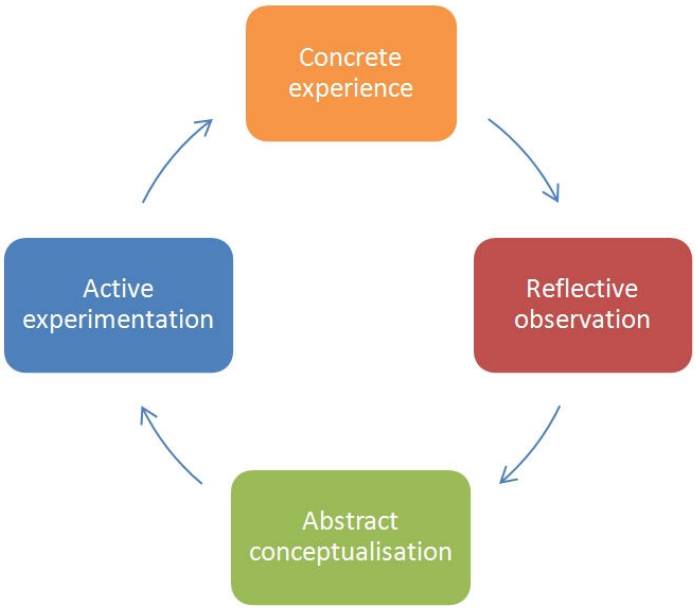
_____ _____

What is Reflection?

Reflection is described by Johns (2013) as “a mirror in which the practitioner can view and focus self within the context of a particular experience, in orde to confront, understand and move towards resolving contradiction between one’s vision and actual practice”. Indeed, students and practitioner can examine and interpret their experiences towards Reflection in roder to gain new understanding and figure out why things are as they are (Johns, 2013). So, the most important benefit of Reflection is searching and identifying strengths and weakness of self practice and self behaviour.

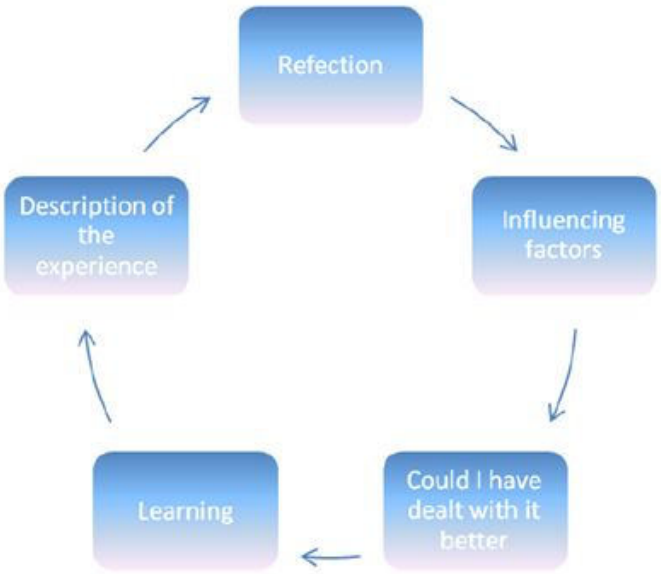
There are different type of reflective cycles made in order to facilitate self reflective practice and structured with a series of logical questions which the subject must ask him or her self.

The first example is Kolb’s reflective model (1984) which is based on experimental learning of every tipe of experience. This cycle starts with the description of a concrete experience. Then it diverge in a reflective observation of what the subject have done. Then the subject has to assimilate the abstract conceptualisation by making hypothesis of experience’s meaning to interpret the fact. Finally there is a conversion from theory to planning active experimentation by which the subject test the hypothesis expressed before.



REFLECTIVE MODEL ACCORDING TO KOLB (2017)

Another example is Johns’ reflective model (Johns, 2000) which is based on Carper’s reflective model (Carper, 1978). This last one was developed for nursing practitioners but is applicable to any field. There are four mainly points in Carper’s model: empirical knowledge, aesthetic knowledge, personal knowledge and ethical knowledge (Carper, 1978). Instead, Johns’ model is based on five questions. In the first one the subject must describe the experience and identify the significant factors. In the second one there is a reflection on the consequences of subject’s previous actions. Then the operator has to



CHARLES DARWIN UNIVERSITY (2018)

think about the influencing factors which affected his or her decision making process. Subsequently, possible other choice and their consequences are analysed. Finally there is a learning from experience on the empirical, aesthetic, personal and ethical point of view (Johns, 2000).

The last example is Gibb's reflective model (Gibbs, 1988) which is the one I used to practice Reflection. I decided to reflect with this type of cycle because it is based on six logical steps that help me to focus the situations, to analyse strengths and weakness of the experiences and to find always something to learn also from bad experiences.

GIBBS REFLECTIVE CYCLE (2015)

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- Reflective model according to Kolbe, 2017. http://www.nicole-brown.co.uk/reflective-model-according-to-kolb/

Osteopathic Practice Standard grid

Sub divisions	Name the course/ module that this refers to	Page number and what type of evidence: 1. patient 2. essay 3. presentation 4. poster	Page number of Any external courses or interest you are using as evidence
-A- COMMUNICATION AND PATIENT PARTNERSHIP			
A1 You must have well-developed interpersonal communication skills and the ability to adapt communication strategies to suit the specific needs of a patient.	Electives	Clinical Logbook 1 Clinical Logbook 4 Clinical Logbook 5 Clinical Logbook 6 Clinical Logbook 7 Clinical Logbook 8 Clinical Logbook 9 Clinical Logbook 14 Clinical Logbook 15 Clinical Logbook 16 Clinical Logbook 17 Clinical Logbook 19 Clinical Logbook 20 Clinical Logbook 21 Clinical Logbook 22 Clinical Logbook 23 Clinical Logbook 24 Clinical Logbook 25 Clinical Logbook 26 Clinical Logbook 27 Clinical Logbook 28 Clinical Logbook 29 Clinical Logbook 30 Reflective Journal 1 Reflective Journal 4 Reflective Journal 10 Reflective Journal 12	

A2 Listen to patients and respect their concerns and preferences.	Electives	Clinical Logbook 1 Clinical Logbook 2 Clinical Logbook 5 Clinical Logbook 7 Clinical Logbook 9 Clinical Logbook 11 Clinical Logbook 12 Clinical Logbook 13 Clinical Logbook 16 Clinical Logbook 21 Clinical Logbook 22 Clinical Logbook 23 Clinical Logbook 24 Clinical Logbook 25 Clinical Logbook 26 Clinical Logbook 27 Clinical Logbook 28 Clinical Logbook 29 Clinical Logbook 30 Reflective Journal 1 Reflective Journal 5 Reflective Journal 7 Reflective Journal 9	
	Tennis Club Como		Reflective Journal 18
	Tennis Club Cantù		Reflective Journal 19
A3 Give patients the information they need in a way that they can understand.	Electives	Clinical Logbook 1 Clinical Logbook 5 Clinical Logbook 7 Clinical Logbook 8 Clinical Logbook 16 Clinical Logbook 18 Clinical Logbook 19 Clinical Logbook 20 Clinical Logbook 21 Clinical Logbook 22 Clinical Logbook 23 Clinical Logbook 24 Clinical Logbook 25 Clinical Logbook 26 Clinical Logbook 27 Clinical Logbook 28 Clinical Logbook 29 Clinical Logbook 30	
	Electives	Reflective Journal 1 Reflective Journal 3 Reflective Journal 10 Reflective Journal 12	

A4 You must receive valid consent before examination and treatment.	Electives	Clinical Logbook 1 Clinical Logbook 2 Clinical Logbook 3 Clinical Logbook 4 Clinical Logbook 5 Clinical Logbook 6 Clinical Logbook 7 Clinical Logbook 8 Clinical Logbook 9 Clinical Logbook 10 Clinical Logbook 11 Clinical Logbook 12 Clinical Logbook 13 Clinical Logbook 14 Clinical Logbook 15 Clinical Logbook 16 Clinical Logbook 17 Clinical Logbook 18 Clinical Logbook 19 Clinical Logbook 20 Clinical Logbook 21 Clinical Logbook 22 Clinical Logbook 23 Clinical Logbook 24 Clinical Logbook 25 Clinical Logbook 26 Clinical Logbook 27 Clinical Logbook 28 Clinical Logbook 29 Clinical Logbook 30 Reflective Journal 1	
A5 Work in partnership with patients to find the best treatment for them.	Electives	Clinical Logbook 3 Clinical Logbook 4 Clinical Logbook 5 Clinical Logbook 7 Clinical Logbook 16 Clinical Logbook 18 Clinical Logbook 23 Clinical Logbook 25 Clinical Logbook 28 Clinical Logbook 29 Reflective Journal 1 Short Reflection LB 8 Long Reflection 1	
	Tennis Club Como		Reflective Journal 18
	Tennis Club Cantù		Reflective Journal 19

A6 Support patients in caring for themselves to improve and maintain their own health.	Electives	Clinical Logbook 1 Clinical Logbook 5 Clinical Logbook 7 Clinical Logbook 8 Clinical Logbook 9 Clinical Logbook 10 Clinical Logbook 13 Clinical Logbook 14 Clinical Logbook 16 Clinical Logbook 18 Clinical Logbook 22 Clinical Logbook 23 Clinical Logbook 28 Clinical Logbook 29 Reflective Journal 1 Reflective Journal 6 Reflective Journal 7 Reflective Journal 9 Reflective Journal 10	
-B- **KNOWLEDGE, SKILLS AND PERFORMANCE**			
B1 You must understand osteopathic concepts and principles, and apply them critically to patient care.	Electives	Clinical Logbook 2 Clinical Logbook 3 Clinical Logbook 4 Clinical Logbook 5 Clinical Logbook 6 Clinical Logbook 7 Clinical Logbook 8 Clinical Logbook 9 Clinical Logbook 10 Clinical Logbook 11 Clinical Logbook 12 Clinical Logbook 14 Clinical Logbook 15 Clinical Logbook 16 Clinical Logbook 17 Clinical Logbook 18 Clinical Logbook 19 Clinical Logbook 20 Clinical Logbook 22 Clinical Logbook 23 Clinical Logbook 25 Clinical Logbook 26 Clinical Logbook 27 Clinical Logbook 28 Clinical Logbook 29 Reflective Journal 2 Reflective Journal 7 Reflective Journal 8 Reflective Journal 11 Reflective Journal 13 Long Reflection 1	

B2 You must have sufficient knowledge and skills to support your work as an osteopath.	Electives	Clinical Logbook 1 Clinical Logbook 2 Clinical Logbook 3 Clinical Logbook 4 Clinical Logbook 5 Clinical Logbook 6 Clinical Logbook 7 Clinical Logbook 8 Clinical Logbook 9 Clinical Logbook 11 Clinical Logbook 15 Clinical Logbook 16 Clinical Logbook 17 Clinical Logbook 18 Clinical Logbook 19 Clinical Logbook 22 Clinical Logbook 23 Clinical Logbook 24 Clinical Logbook 25 Clinical Logbook 26 Clinical Logbook 27 Clinical Logbook 28 Clinical Logbook 29 Clinical Logbook 30 Reflective Journal 1 Reflective Journal 2 Reflective Journal 3 Reflective Journal 7 Reflective Journal 8 Reflective Journal 11 Long Reflection 1 Long Reflection 2 Long Reflection 3 Long Reflection 4 Long Reflection 5 Long Reflection 6	
	ICOM College		Reflective Journal 14
	Advanced Neuromuscolar Osteopathic Academy		Reflective Journal 17
	British Institute		Reflective Journal 15

B3 Recognise and work within the limits of your training and competence.	Electives	Clinical Logbook 1 Clinical Logbook 5 Clinical Logbook 7 Clinical Logbook 9 Clinical Logbook 13 Clinical Logbook 16 Clinical Logbook 21 Clinical Logbook 22 Clinical Logbook 23 Clinical Logbook 24 Clinical Logbook 25 Clinical Logbook 26 Clinical Logbook 29 Reflective Journal 3 Reflective Journal 9 Long Reflection 1 Long Reflection 2 Long Reflection 3 Long Reflection 4 Long Reflection 5 Long Reflection 6	
	ICOM College		Reflective Journal 14
	Advanced Neuromuscolar Osteopathic Academy		Reflective Journal 17
	British Institute		Reflective Journal 15
	Tennis Club Cantù		Reflective Journal 19

B4 Keep your professional knowledge and skills up to date.	Electives	Clinical Logbook 3 Clinical Logbook 4 Clinical Logbook 5 Clinical Logbook 6 Clinical Logbook 7 Clinical Logbook 8 Clinical Logbook 9 Clinical Logbook 11 Clinical Logbook 12 Clinical Logbook 13 Clinical Logbook 15 Clinical Logbook 18 Clinical Logbook 21 Clinical Logbook 24 Clinical Logbook 25 Clinical Logbook 26 Clinical Logbook 29 Clinical Logbook 30 Reflective Journal 2 Reflective Journal 3 Reflective Journal 4 Reflective Journal 9 Reflective Journal 11 Reflective Journal 13 Long Reflection 1 Long Reflection 2 Long Reflection 3 Long Reflection 4 Long Reflection 5 Long Reflection 6	
	ICOM College		Reflective Journal 14
	Advanced Neuromuscolar Osteopathic Academy		Reflective Journal 17
	British Institute		Reflective Journal 15
-C- **SAFETY AND QUALITY IN PRACTICE**			

C1 You must be able to conduct an osteopathic patient evaluation sufficient to make a working diagnosis and formulate a treatment plan.	Electives	Clinical Logbook 1 Clinical Logbook 2 Clinical Logbook 3 Clinical Logbook 4 Clinical Logbook 5 Clinical Logbook 6 Clinical Logbook 7 Clinical Logbook 8 Clinical Logbook 9 Clinical Logbook 10 Clinical Logbook 11 Clinical Logbook 12 Clinical Logbook 14 Clinical Logbook 15 Clinical Logbook 16 Clinical Logbook 18 Clinical Logbook 19 Clinical Logbook 20 Clinical Logbook 21 Clinical Logbook 24 Clinical Logbook 25 Clinical Logbook 26 Clinical Logbook 27 Clinical Logbook 28 Clinical Logbook 29 Clinical Logbook 30	
	Electives	Reflective Journal 2 Reflective Journal 7 Reflective Journal 8 Reflective Journal 11 Reflective Journal 13	

C2 You must be able to formulate and deliver a justifiable osteopathic treatment plan or an alternative course of action.	Electives	Clinical Logbook 2 Clinical Logbook 3 Clinical Logbook 4 Clinical Logbook 5 Clinical Logbook 6 Clinical Logbook 7 Clinical Logbook 8 Clinical Logbook 9 Clinical Logbook 10 Clinical Logbook 11 Clinical Logbook 12 Clinical Logbook 14 Clinical Logbook 15 Clinical Logbook 16 Clinical Logbook 17 Clinical Logbook 18 Clinical Logbook 20 Clinical Logbook 21 Clinical Logbook 24 Clinical Logbook 25 Clinical Logbook 26 Clinical Logbook 27 Clinical Logbook 28 Clinical Logbook 29 Reflective Journal 2 Reflective Journal 7 Reflective Journal 8 Reflective Journal 11 Reflective Journal 13	
C3 Care for your patients and do your best to understand their condition and improve their health.	Electives	Clinical Logbook 1 Clinical Logbook 2 Clinical Logbook 7 Clinical Logbook 13 Clinical Logbook 21 Clinical Logbook 24 Clinical Logbook 25 Clinical Logbook 26 Clinical Logbook 28 Clinical Logbook 29 Clinical Logbook 30 Reflective Journal 1 Reflective Journal 2 Reflective Journal 3 Reflective Journal 7 Reflective Journal 9	
	Tennis Club Cantù		Reflective Journal 19

C4 Be polite and considerate with patients.	Electives	Clinical Logbook 1 Clinical Logbook 5 Clinical Logbook 7 Clinical Logbook 9 Clinical Logbook 13 Clinical Logbook 14 Clinical Logbook 17 Clinical Logbook 19 Clinical Logbook 22 Clinical Logbook 23 Clinical Logbook 27 Clinical Logbook 29 Clinical Logbook 30 Reflective Journal 1 Reflective Journal 3 Reflective Journal 5 Reflective Journal 7 Reflective Journal 9 Reflective Journal 10	
C6 Respect your patients' dignity and modesty.	Electives	Clinical Logbook 1 Clinical Logbook 9 Clinical Logbook 11 Clinical Logbook 19 Clinical Logbook 13 Clinical Logbook 21 Clinical Logbook 25 Clinical Logbook 26 Clinical Logbook 27 Clinical Logbook 28 Reflective Journal 5 Reflective Journal 9	
C8 Ensure that your patient records are full, accurate and completed promptly.	Electives	Clinical Logbook 8 Clinical Logbook 9 Clinical Logbook 10 Clinical Logbook 11 Clinical Logbook 12 Clinical Logbook 14 Clinical Logbook 15 Clinical Logbook 16 Clinical Logbook 19 Clinical Logbook 20 Clinical Logbook 24 Reflective Journal 4	
C9 Act quickly to help patients and keep them from harm.	Electives	Clinical Logbook 2 Clinical Logbook 7 Clinical Logbook 10 Clinical Logbook 16 Clinical Logbook 24 Reflective Journal 1 Reflective Journal 5	
-D- PROFESSIONALISM			

D1 You must consider the contributions of other healthcare professionals to ensure best patient care.	Electives	Clinical Logbook 7 Clinical Logbook 13 Clinical Logbook 16 Clinical Logbook 18 Clinical Logbook 19 Clinical Logbook 22 Clinical Logbook 23 Clinical Logbook 25 Clinical Logbook 26 Clinical Logbook 27 Clinical Logbook 28 Clinical Logbook 29 Clinical Logbook 30 Long Reflection 1 Reflective Journal 6	
	Tennis Club Como		Reflective Journal 18
	Tennis Club Cantù		Reflective Journal 19
D2 You must respond effectively to requirements for the production of high-quality written material and data.	Electives	Clinical Logbook 8 Clinical Logbook 16 Clinical Logbook 22 Clinical Logbook 23 Clinical Logbook 26 Clinical Logbook 27 Clinical Logbook 28 Clinical Logbook 29 Clinical Logbook 30 Reflective Journal 4	
D3 You must be capable of retrieving, processing and analysing information as necessary.	Electives	Clinical Logbook 1 Clinical Logbook 7 Clinical Logbook 8 Clinical Logbook 21 Clinical Logbook 25 Clinical Logbook 26 Clinical Logbook 29 Reflective Journal 1 Reflective Journal 4 Reflective Journal 10	
D4 Make sure your beliefs and values do not prejudice your patients' care.	Electives	Clinical Logbook 1 Clinical Logbook 4 Clinical Logbook 7 Clinical Logbook 16 Clinical Logbook 22 Clinical Logbook 23 Clinical Logbook 24 Clinical Logbook 25 Clinical Logbook 26 Reflective Journal 1 Reflective Journal 6 Reflective Journal 12	

D5 You must comply with equality and anti-discrimination laws.	Electives	Clinical Logbook 7 Clinical Logbook 16 Clinical Logbook 24 Clinical Logbook 25 Clinical Logbook 28 Reflective Journal 1 Reflective Journal 12	
D6 Respect your patients' rights to privacy and confidentiality.	Electives	Clinical Logbook 1 Clinical Logbook 2 Clinical Logbook 3 Clinical Logbook 4 Clinical Logbook 5 Clinical Logbook 6 Clinical Logbook 7 Clinical Logbook 8 Clinical Logbook 9 Clinical Logbook 10 Clinical Logbook 11 Clinical Logbook 12	
	Electives	Clinical Logbook 13 Clinical Logbook 14 Clinical Logbook 15 Clinical Logbook 16 Clinical Logbook 17 Clinical Logbook 18 Clinical Logbook 19 Clinical Logbook 20	
D7 Be open and honest when dealing with patients and colleagues and respond quickly to complaints.	Electives	Clinical Logbook 7 Clinical Logbook 8 Clinical Logbook 16 Clinical Logbook 19 Clinical Logbook 24 Clinical Logbook 27 Clinical Logbook 28 Reflective Journal 1 Reflective Journal 3 Reflective Journal 12	
D9 Keep comments about colleagues or other healthcare professionals honest, accurate and valid.	Electives	Clinical Logbook 3 Clinical Logbook 7 Clinical Logbook 12 Clinical Logbook 13 Clinical Logbook 27 Clinical Logbook 30	
D10 Ensure that any problems with your own health do not affect your patients.	Electives	Reflective Journal 6	

D11 Be aware of your role as a healthcare provider to promote public health.	Electives	Clinical Logbook 1 Clinical Logbook 2 Clinical Logbook 3 Clinical Logbook 4 Clinical Logbook 5 Clinical Logbook 6 Clinical Logbook 7 Clinical Logbook 8 Clinical Logbook 9 Clinical Logbook 10 Clinical Logbook 11 Clinical Logbook 12 Clinical Logbook 13 Clinical Logbook 14 Clinical Logbook 15 Clinical Logbook 16 Clinical Logbook 17 Clinical Logbook 18 Clinical Logbook 19 Clinical Logbook 20 Clinical Logbook 22 Clinical Logbook 23 Clinical Logbook 24 Clinical Logbook 25 Clinical Logbook 26 Clinical Logbook 27 Clinical Logbook 28 Clinical Logbook 29 Clinical Logbook 30 Reflective Journal 6	
D12 Take all necessary steps to control the spread of communicable diseases.	Electives	Clinical Logbook 1 Clinical Logbook 2 Clinical Logbook 3 Clinical Logbook 4 Clinical Logbook 5 Clinical Logbook 6 Clinical Logbook 7 Clinical Logbook 8 Clinical Logbook 9	

	Electives	Clinical Logbook 10 Clinical Logbook 11 Clinical Logbook 12 Clinical Logbook 13 Clinical Logbook 14 Clinical Logbook 15 Clinical Logbook 16 Clinical Logbook 17 Clinical Logbook 18 Clinical Logbook 19 Clinical Logbook 20 Clinical Logbook 21 Clinical Logbook 22 Clinical Logbook 23 Clinical Logbook 24 Clinical Logbook 25 Clinical Logbook 26 Clinical Logbook 27 Clinical Logbook 28 Clinical Logbook 29 Clinical Logbook 30 Reflective Journal 6	
D13 Comply with health and safety legislation.	Electives	Clinical Logbook 1 Clinical Logbook 2 Clinical Logbook 3 Clinical Logbook 4 Clinical Logbook 5 Clinical Logbook 6 Clinical Logbook 7 Clinical Logbook 8 Clinical Logbook 9 Clinical Logbook 10 Clinical Logbook 11 Clinical Logbook 12 Clinical Logbook 13 Clinical Logbook 14 Clinical Logbook 15 Clinical Logbook 16 Clinical Logbook 17 Clinical Logbook 18 Clinical Logbook 19 Clinical Logbook 20 Clinical Logbook 21 Clinical Logbook 22 Clinical Logbook 23 Clinical Logbook 24 Clinical Logbook 25 Clinical Logbook 26 Clinical Logbook 27 Clinical Logbook 28 Clinical Logbook 29 Clinical Logbook 30 Reflective Journal 6	

D14 Act with integrity in your professional practice.	Electives	Clinical Logbook 7 Clinical Logbook 8 Clinical Logbook 9 Clinical Logbook 10 Clinical Logbook 11 Clinical Logbook 12 Clinical Logbook 14 Clinical Logbook 15 Clinical Logbook 16 Clinical Logbook 19 Clinical Logbook 20 Clinical Logbook 21 Reflective Journal 1	
	Tennis Club Como		Reflective Journal 18
	Tennis Club Cantù		Reflective Journal 19

Clinical Logbook Table

	Gender	Age	Occupation	Presenting complaint(s)	Area treated	Observed/ treated
1	female	43	ex-worker	pain in the upper part of right thorax which irradiates to right shoulder	right shoulder girdle	observed
2	male	78	retired	low back pain	lumbar spine and right knee	observed
3	female	62	housewife	low back pain	abdomen and lumbar spine	observed
4	male	58	policeman	plantar fascitis, knee pain and gluteal pain	right lower limb	observed
5	male	66	employee	shoulder pain and thigh pain	right shoulder girdle	observed
6	male	31	employee	forearm pain	upper right limb	observed
7	male	50	unemployed	knee pain	the whole body	observed
8	female	58	employee	low back pain	lumbar spine	treated
9	female	16	student	postural control	abdomen and leg lower limb	treated
10	male	53	unemployed	postural control	thoracic spine and right foot	treated
11	female	50	employee	pain in the lower part of mandible	front of the neck	treated
12	female	51	employee	cervical pain with headache and heaviness in the lower limbs	c-section scar	treated
13	female	49	employee	low back pain	sacrum and occipital	observed
14	male	34	employee	ankle sprain	right foot	treated
15	female	48	restorer	groin pain	T4 and right psoas	treated
16	male	55	merchant	neurogenic claudication	not treated	treated
17	male	24	student	ankle pain	right ankle	observed
18	female	46	employee	shoulder pain	not treated	observed
19	female	20	student	low back pain	not treated	treated
20	female	21	student	scapular pain	right scapolomeral girdle	treated
21	male	35	worker	cervical pain	left arm and left shoulder	treated

Clinical Logbook Table

22	male	57	employee	knee pain	right lower limb	observed
23	female	67	retired	hip pain	abdomen	treated
24	female	69	retired	low back pain	left gluteus muscles	observed
25	female	23	student	right occipital pain	trapezius and CD spine	treated
26	male	52	road hauler	pain in the left shoulder	not treated	treated
27	female	22	acting student	headache	diaphragm and abdomen	treated
28	male	35	workman	knee pain	right calf	treated
29	female	14	student	ankle pain	not treated	treated
30	male	48	engineer	no pain	diaphragm and ribs cage	treated

Clinical log book 1

Date: March 2016

Observed ☑

Treated ☐

Patient front sheet included? ☒

Number: 1	Sex: female	Age: 43	Area treated: right shoulder girdle

Presentation

The patient is an ex-worker, overweight, diabetic (diabetes mellitus from one year) and smoker. She came to ICOM Clinic complaining:

- A pain in the upper region of thorax which irradiated to the right shoulder. This pain started 10 days before when she woke up in the morning. She described the pain as a burning during right arm movements and during right sidebending of head, but it isn't specific. She took NSAID ands went to a massage therapist, but the pain didn't change.
- A joint stiffness in spine from C5 to D2 during head's movements. This joint disfunction had started after four whiplashes during last 20 years.
- Weakness on upper limns associated with tremor when she brought heavy bags. This discomfort had appeared after the first car crash in 1996 and had become more and more manifest through the follow years with the assumption of antidepressant drugs.

The patient had been the first car crash in 1996 and it had been the worst one. She hadn't had the seat belt and she had crashed into the windshield and broken her face with a cranial trauma. Unfortunately, she entered in a psychosis state after the surgery which had been diagnosed as depressive bipolar disorder. After that, she started taking many antidepressant and other drugs (Medalina, Depakin, Lasix, Eutirox).

The patient had suffered from several pneumonitis and one acute DVT in 2014.

Hypothesis

1. Referred pain due to heart disease
2. Pancoast cancer
3. Radiculopathy of C5-C6
4. Costovertebral joint disfunction
5. Herpes Zoster

Red flags ☑

What and why? This patient presented two important Red flags in the differential diagnosis. The first one was a referred pain due to heart disease because the heart could irradiate an unspecific pain to the right shoulder. Furthermore, the patient was diabetic, overweight and smoker, which are all risk factors of atherosclerosis and cardiovascular disease. Moreover the pain had appeared suddenly. The second one was Pancoast cancer which is the cancer of the upper region of the lungs. This type of cancer typically compresses brachial plexus and creates shoulder pain. Furthermore, the patient was smoker and she had suffered from several pneumonitis.

Examinations to support hypothesis

1. Medical examination of heart was performed to rule out the first red flag. Peripheral pulses, blood pressure and cardiac auscultation were all good. Then the pain didn't appear during physical exertion but it was a mechanical pain related to head and right arm movements. So, this red flag was excluded.
2. Medical examination of lungs was performed to rule out the second red flag. Expansion, percussion and auscultation of rib cage and lungs were all good. Then the patient referred neither breathing problems nor out of breath sensation at that moment. Furthermore, she didn't refer loss of weight during last months. Finally the pain didn't appear during physical exertion but it was a mechanical pain related to head and right arm movements. So, this red flag was excluded.
3. Neurological examination of C5-C6 roots was performed but the patient presented neither abnormal sensations nor loss of strength. Furthermore, bicipital reflex was good and the patient didn't refer pins and needles sensation. So, this hypothesis was excluded.
4. On physical examination the patient present an internal rotation of both shoulder girdles, especially the right one. On palpation there was a decreased range of movement of right shoulder due to a hypomobility of clavicle and a somatic disfunction of D1 and K1. The patient's pain was a mechanical pain and it was evoked with orthopaedic test for K1.
5. Herpes Zoster was excluded because there were any skin rash. Furthermore the pain wasn't on a specific dermatome and it was a mechanical pain.

Diagnosis

Articular stiffness of right shoulder girdle due to the presence of a somatic disfunction in D1 with costovertebral joint disfunction of K1 and clavicle hypomobility.

Treatment and patient advice

The treatment aimed to reduce the costovertebral joint disfunction of K1 with soft tissue on shoulder girdle's muscles and articulatory techniques on K1 and clavicle. Then, the operator worked on somatic disfunction of D1 with articulatory technique and HVLA technique. At the end, the operator performed an inhibition of the anterior closure chain of right upper limb.

Reflective content: how does this patient fit into OPS grid?

Tick if the patient will be useful for

A. COMMUNICATION AND PATIENT PARTNERSHIP ☑

Sub section number short reflection:

A1. I learnt how to communicate with a patient in a depressive state.

A2. The patient preferred to not undressed in front of male students, so they went out from the room.

A3. The patient was a bit confused and dazed because of the numerous drugs she took, so I saw how the operator communicated with the patient in order to be understandable.

A4. Every patient must give him or her consent and signs the informed consent before examination and treatment. In this way, the patient is always informs about who will perform the treatment and how the treatment will be performed.

A6. The patient didn't take care of herself because of her state of health. So the tutor showed us how to explain to the patient the importance of this aspect to improve her own health.

A. KNOWLEDGE, SKILLS AND PERFORMANCE ☑

Sub section number short reflection:

B2. I couldn't be able to manage a depressed patient because I didn't know what are the mainly behaviours and reactions in this case. Furthermore, I didn't know the influences on body systems of all drugs. So I decided to deepen this pathology.

B3. Osteopathy cannot direct work on depressive state and symptoms.

B. SAFETY AND QUALITY IN PRACTICE ☑

Sub section number short reflection:

C1. In this case there were many red flags and the most important thing were making a correct diagnosis to exclude the red flags. Furthermore, the operator also performed a complete physical examination and found the priority.

C3. In this case the operator cared for the patient because of her psychological pathology. Is always good try to put ourselves in the shoes of the patient to understand patient's point of view.

C4. The operator was particularly polite with the patient considering her pathology.

C6. Male students went out of the room because the patient didn't want to undressed in front of them.

C. PROFESSIONALISM ☑

Sub section number short reflection:

D3. There were a lot of informations during the anamnesis, and the operator showed us how to catch the information and to analyse them in order to make a discussion and a right diagnosis.

D4. The treatment of this patient didn't be prejudice despite her psychological pathology. Indeed, the treatment was performed with more attention than usual.

D6. Personal informations about the patient are always keep reserved in respect of patient's privacy.

D11, D12, D13. All necessary steps were taken to promote public health basing on health and safety legislation.

Any Additional evidence ☑

Reflective Journal 1

Page number:

Clinical log book 2

Date: April 2016

Observed ☑

Treated ☐

Patient front sheet included? ☒

Number: 2	Sex: male	Age: 78	Area treated: lumbar spine and right knee

Presentation

The patient is retired and normal weight. He referred a low back pain appeared in an acute way 20 days before after he had fallen down the stairs. He also had sprained his right knee in that fall. He had gone to the emergency room but there were any fractures or pathologies. Nowadays, the pain was already present in the morning and localised in the right multifidus triangle and in the right gluteus. This pain is associated to a burning in the third distal internal part of the right thigh and in the medial part of the right knee. The patient brought a x-ray of lumbar spine; there was an initial arthritis of L4-L5-S1. He had been taking cortisone drugs to reduce arthrosis pain.

Hypothesis

1. Fracture of femoral head

2. Hip arthritis

3. Contracture of gluteus and multifidus muscles

4. Sacroiliac joint impingement

5. Medial collateral ligament sprain of right knee

6. Medial meniscus tear of right knee

7. Strain of pes anserinus' muscles of the right knee

Red flags ☑

What and why? Fracture of femoral head is an important red flag because it could evolve in a necrosis of the femoral head. The patient referred a pain in the medial part of the knee after a trauma on pelvic girdle. The obturator nerve innervates the articular part of hip joint and has its cutaneous distribution in the medial part of knee and of the third distal thigh. So, an hip disorder could refer pain in that part of thigh and knee.

Examinations to support hypothesis

1-2. On x-ray there were any signs of hip or femoral head fracture or arthritis. Furthermore the pain wasn't evoke with orthopaedic tests on hip indeed they were all negative. The knee pain wasn't associate with hip movements. So, these red flag and hypothesis were excluded.

3-4. On physical examination there were a gluteus muscles spasm and hypomobilty of the right sacroiliac joint with tenderness during flexion and extension movements of trunk. furthermore there were a somatic dysfunction of L4-L5.

5-6. There weren't signs of inflammation in the right knee. Orthopaedic tests on medial collateral ligament and medial meniscus were all negative. So, these hypothesis waere excluded.

7. On physical examination the right knee was more valgus than the left one. The pain was evoked during palpation and stretch of pes anserinu's muscles (semitendinous, gracilis, sartorius).

Diagnosis

Low back pain due to impingement of sacroiliac joint, somatic disfunction of L4-L5 and consequent gluteus muscles contracture. Right knee pain due to strain of pes anserinus' muscles.

Treatment and patient advice

The treatment started with a general soft tissue on lumbar and gluteal muscles which evolved in a specific inhibition of multifidus and gluteus medium and minimus muscles. Then the operator performed articulatory and HVLA technique on somatic disfunction L4-L5 and on the right sacroiliac joint. A general soft tissue of abductor thigh muscles was practiced. Finally, the operator performed articulatory technique to reduce the knee valgus and decrease the stretch of pes anserinu's muscles.

Reflective content: how does this patient fit into OPS grid?

Tick if the patient will be useful for

A. COMMUNICATION AND PATIENT PARTNERSHIP ☑

Sub section number short reflection:

A2. The patient was a little concerned but the operator didn't take into account this aspect. I think it would have been better If the operator had reassure the patient oh his condition.

A4. Every patient must give him or her consent and signs the informed consent before examination and treatment. In this way, the patient is always informs about who will perform the treatment and how the treatment will be performed.

B. KNOWLEDGE, SKILLS AND PERFORMANCE ☑

Sub section number short reflection:

B1. The operator performed a correct physical examination and was able to apply osteopathic concepts to identify the priority. However, the operator didn't take into account all the body systems. I think it would have been more interesting If the operator had linked the all body.

B2. The operator applied his osteopathic knowledge to make a complete anamnesis and support his osteopathic thinking.

C. SAFETY AND QUALITY IN PRACTICE ☑

Sub section number short reflection:

C1. The operator performed a correct physical examination and was able to apply osteopathic concepts to identify the priority. However, the operator didn't take into account all the body systems. I think it would have been more interesting If the operator had linked the all body.

C2. The operator was able to plan the osteopathic treatment and justified it. It has been useful to me.

C3. The patient was elderly and scared of his problem. I think the operator should have had more humanity with the patient.

C9. The patient walked with a crutch when came to the visit. After the treatment the operator wanted to see if the patient was able to walk without the crutch. But the operator was always ready to act quickly in case of the patient felt unstable.

D. PROFESSIONALISM ☑

Sub section number short reflection:

D6. Personal informations about the patient are always keep reserved in respect of patient's privacy.

D11, D12, D13. All necessary steps were taken to promote public health basing on health and safety legislation.

Any Additional evidence ☒

Clinical log book 3

Date: May 2016

Observed ☑

Treated ☐

Patient front sheet included? ☒

Number: 3	Sex: female	Age: 62	Area treated: abdomen and lumbar spine

Presentation

The patient is a housewife and normal weight. She came to ICOM Clinic complaining a bilateral low back pain which irradiated alternately on right or left side. The pain suddenly had appeared one year before when she was getting up off the couch. She had taken NSAID drugs and the pain had got better, but It still was present as a chronic discomfort. She felt pain when she moved in the bed during the night. The pain was already present in the morning and got better after some hours: it wasn't associate to hipomobility or joint stiffness. In the medical history the patient referred many acute events of low back pain: the first one was in 1995 and the last one was one month before.

The left lower limb were shorter than the right one because of a femoral fracture cured with incorrect metal plate when she was 14.

The patient had undergone to two cesarean sections. The first one was unplanned in 1992; the second one was planned in 1994.

Hypothesis

1. Chronic contracture of quadratus lomborum and multifidus muscles

2. Bulging of L5-S1 intervertebral disc

3. Degenerative arthritis of L5-S1

Red flags ☒

Examinations to support hypothesis

1. On palpation the pain was evoked with palpation of quadratus lomborum and multifidus muscles. Furthermore, on physical examination the patient presented a great disequilibrium on anterior-posterior axis with the abdomen more anterior then the head and a increased lumbar lordosis. This spine position creates a lumbar muscles contracture and it's maintain by the two cesarean scars. Indeed, the first acute episode had been one year after the second cesarean section. Another aspect was that NSAID improved her pain.

2. Orthopaedic tests were performed to evaluate disc pain; some of these were positive and other were negative. It wasn't possible to exclude this hypothesis because the patient presented pain after maintain position, which is index of disc disorder. Furthermore, the pain didn't totally disappear with NSAID; this could be index of disc disorder because NSAID drugs don't take big effect on disc.

3. The pain wasn't associated to stiffness or hipomobility of lumber spine. Furthermore the symptoms had been lasting since she was younger and the type of pain had been always the same. So, this hypothesis was excluded.

Diagnosis

Low back pain due mainly to chronic contracture of quadratus lomborum and multifidus muscles because of an altered posture secondary to cesarean sections. This imbalance could also provoke an overload on L5-S1 disc with consequent bulging.

Treatment and patient advice

Osteopathic treatment is primarily based on cesarean scar tissue release in correlation to lumbar muscles inhibition and articulatory techniques on lumbar spine. The the operato performed a direct inhibition or fascial release of pelvic floor, thoracic diaphragm, thoracic outlet, mouth floor and tentorium cerebelli to rebalance body pressure on the anterior-posterior axis.

Reflective content: how does this patient fit into OPS grid?

Tick if the patient will be useful for

A. COMMUNICATION AND PATIENT PARTNERSHIP ☑

Sub section number short reflection:

A4. Every patient must give him or her consent and signs the informed consent before examination and treatment. In this way, the patient is always informs about who will perform the treatment and how the treatment will be performed.

A5. The patient needed a muscular reinforce of the abdomen muscles, so the tutor gave some advice to the patient to maintain the right posture and improved abdomen state between the weekly treatments. I think that cooperation with the patient was essential to decrease her pain.

B. KNOWLEDGE, SKILLS AND PERFORMANCE ☑

Sub section number short reflection:

B1. The operator didn’t link the cesarean section in the right way during treatment so the tutor helped him.

B2. The operator didn’t know which are the influence due to mandibular disorders. I didn’t know too, so I studied it in a more deepen way.

B4. In this first visit there were two new topic and I studied it after the visit. Now, I will keep my professional knowledge on this topic up to date.

C. SAFETY AND QUALITY IN PRACTICE ☑

Sub section number short reflection:

C1. The operator performed an incomplete physical examination because I didn’t consider the cesarean scar and the mandibular disorder and the tuto helped him. I learnt how to integrate this two system on posture.

C2. The tutor planned an interesting osteopathic treatment. I learnt how to treat a cesarean scar.

D. PROFESSIONALISM ☑ Sub section number short reflection: **D6.** Personal informations about the patient are always keep reserved in respect of patient's privacy. **D9.** The patient had a lower limb shorter than the other one because of an incorrect femoral metal plate, but the tutor taught to students to not make comments about it. **D11, D12, 13.** All necessary steps were taken to promote public health basing on health and safety legislation.
Any Additional evidence ☑ Reflective Journal 2 Page number:

Clinical log book 4

Date: September 2016

Observed ☑

Treated ☐

Patient front sheet included? ☒

Number: 4	Sex: male	Age: 58	Area treated: right lower limb

Presentation

The patient was a policeman and normal weight. He came to ICOM Clinic complaining:

- A pain at the soles of the right feet due to plantar fasciitis and a calcaneal spine (which had been diagnosed two years before). He had undergone to cortisone injections but they hadn't taken effect. Then, he had tried three cycles of shock waves and the symptoms improved. He referred actually a pain in the lateral part of the right knee.
- A widespread pain in the gluteus which irradiated in the middle of the posterior part of thigh. This pain didn't have a specific onset. It had appeared when the patient had seated in the car, then it had lasted for some hours.

Hypothesis

1. Contracture of lateral muscular chain of lower right limb
2. Piriformis syndrome with compression of posterior femoral cutaneous nerve
3. Radiculopathy S1

Red flags ☒

Examinations to support hypothesis

1. On physical examination the patient had a right lateral pelvic tilt with contracture of the all lateral muscular chain of lower right limb. There were dysfunction of subtalar joint, mid tarsal joint and fibula joint with stretch of plantar fascia, fibularis, tensor fascia lata and gluteus muscles. So, the two pains seemed to be related and based on an altered posture.
2. There were any signs or neurological symptoms. Indeed, neurological orthopaedic tests were all negative. Furthermore, piriformis muscle wasn't contract or inflamed.
3. There were any signs or neurological symptoms. Indeed, neurological orthopaedic tests were all negative.

Diagnosis

Contracture of lateral muscular chain of lower right limb (plantar fascia, fibularis, tensor fascia lata and gluteus muscles) because of an abnormal posture on latero-lateral axis.

Treatment and patient advice

The treatment started with inhibition of plantar fascia combined with articulatory techniques on the forefoot, mid-foot and back foot. Then the operator performed inhibition of fibularis, tensor fascia lata and gluteus muscles. Finally the operator practiced HVLA technique on subtalar joint, mid tarsal joint and fibula joint.

Reflective content: how does this patient fit into OPS grid?

Tick if the patient will be useful for

A. COMMUNICATION AND PATIENT PARTNERSHIP ☑

Sub section number short reflection:

A1. The patient was a extremely serious person, he also wore the uniform. The operator changed his interpersonal communication to adapt himself to the patient.

A4. Every patient must give him or her consent and signs the informed consent before examination and treatment. In this way, the patient is always informs about who will perform the treatment and how the treatment will be performed.

A5. The tutor suggested the usage of a support for the heel and the patient agreed to buy it in order to reduce the plantar pain.

B. KNOWLEDGE, SKILLS AND PERFORMANCE ☑

Sub section number short reflection:

B1. The operator apply osteopathic concepts during the treatment of the plantar fascia because it couldn't be directly treated but the operator worked on the whole leg.

B2. The operator had sufficient knowledge about the topic to understand what was wrong and to make a right diagnosis.

B4. Even if I had only observed, my knowledge about the treatment of plantar fasciitis was improved.

C. SAFETY AND QUALITY IN PRACTICE ☑

Sub section number short reflection:

C1. The operator performed a complete and interested physical examination on patient and I learnt how to analyse the whole lower limb from foot up.

C2. The operator planned a logical and efficient treatment for this patient and the tutor gave just some advices.

D. PROFESSIONALISM ☑

Sub section number short reflection:

D4. I felt initially embarrassed when I saw the uniform but the operator instead was quiet and became more serious

D6. Personal informations about the patient are always keep reserved in respect of patient's privacy.

D11,D12,D13. All necessary steps were taken to promote public health basing on health and safety legislation.

Clinical log book 5

Date: September 2016

Observed ☑

Treated ☐

Patient front sheet included? ☒

Number: 5	Sex: male	Age: 66	Area treated: right shoulder

Presentation

The patient is an employee who practices ballroom dancing three times a week, for three hours every time, for more than twenty years. He refers a pain in the posterior region of the right shoulder that started about twenty years ago. This pain is like a pin aggravated by the movement of extension and abduction of the shoulder, and it gets better with warmth.

He also refers a pain in the anterior-lateral region of the right thigh with lost of sensibility; it improves with ice and physical activity and gets worse with the belt. X-Ray, MRI and electromyography are all negative.

Hypothesis

1. Trigger point of triceps
2. Arthrosis of shoulder joint
3. Chronic contracture of shoulder's posterior muscles (triceps, posterior deltoid, infraspinatus, teres major and minor)
4. Compression and inflammation of anterior cutaneous femoral nerve
5. Radiculopathy of L2

Red flags ☒

Examinations to support hypothesis

1. The pain can't be caused by a trigger point because it appears with shoulder's movement and not with the compression of the muscle.

2. The pain can't be due to arthrosis because during passive movement it didn't appear and because it gets better with warmth. In case of arthrosis, in fact, the warm aggravates the pain because there is an inflammation in the joint.

3. The pain is attributable to a chronic contracture of shoulder's posterior muscles because it is aggravated by active movements and improves with warmth. The patient, in fact, during ballroom dancing must support his lady with the right shoulder in that position (abduction and extension) at all times using the posterior muscles.

4. The pain in the thigh can be due to a compression and inflammation of anterior cutaneous femoral nerve under the inguinal ligament because if he wears the belt the sensibility gets worse and because the symptoms gets better with ice.

5. A radiculopathy of L2 is excluded because the reduction of sensitivity is not associated with spine movement and because the instrumental exams and neurological tests are all negative.

Diagnosis

Shoulder's posterior muscles contracture and inflammation of anterior cutaneous femoral nerve

Treatment and patient advice

The operator makes general soft tissue techniques on the dorsal muscles and a specific inhibition of posterior deltoid, infraspinatus, teres major, teres minor and triceps. Then the operator performs a general treatment on the posterior muscle chain of upper limb, an articulate technique in the D1-D5 tract of spine with and a HVLA in the same region.

Reflective content: how does this patient fit into OPS grid?

Tick if the patient will be useful for

A. COMMUNICATION AND PATIENT PARTNERSHIP ☑

Sub section number short reflection:

A1, A2. In this case the tutor was too hasty during the conversation with the patient.

A3. The patient was elderly, do the operator told him the suggestions in a clear and simple way.

A4. Every patient must give him or her consent and signs the informed consent before examination and treatment. In this way, the patient is always informs about who will perform the treatment and how the treatment will be performed.

B. KNOWLEDGE, SKILLS AND PERFORMANCE ☑

Sub section number short reflection:

B1. The operator applied the osteopathic concepts on the shoulder but not on the thigh because of the tutor who said that osteopathy couldn't improve meralgia paresthetica.

B2. I wouldn't have enough knowledge about the topic so I asked to the tutor more explanations.

B3. In this observation I learnt that in case of inflammation of a nerve due to a mechanical compression, I can't able to improve the sensitivity until the acute inflammation in the local region is not over.

B4. I looked for other informations by myself because the tutor didn't completely answer to my question.

C. SAFETY AND QUALITY IN PRACTICE ☑

Sub section number short reflection:

C1, C2. The operator conducted a correct and complete physical osteopathic evaluation and planned the treatment in a logical way.

C4. I think the operator would have been more polite than the tutor.

D. PROFESSIONALISM ☑ Sub section number short reflection: **D6.** Personal informations about the patient are always keep reserved in respect of patient's privacy. **D11, D12, D13.** All necessary steps were taken to promote public health basing on health and safety legislation.
Any Additional evidence ☑ Reflective Journal 3 Page number:

Clinical log book 6

Date: October 2016

Observed ☑

Treated ☐

Patient front sheet included? ☒

Number: 6	Sex: male	Age: 31	Area treated: upper right limb

Presentation

The patient is an office worker and uses the computer. He refers a pain in the distal 3rd of right forearm that started about two weeks earlier during a Tennis match. This pain is a burning which radiates mainly down to 2nd and 3rd fingers and up to deltoid. The pain is aggravated by playing tennis, abduction of the arm, lifting something heavy. During the day he refers a pain like pins near wrist when he puts the hand on the table as he gets up from the chair.

Hypothesis

1. Strain of flexor carpi muscles

2. Overstretching of flexor carpi muscles

3. Contracture of flexor carpi muscles

4. Epitrochleitis

5. Wrist sprain

Red flags ☒

Examinations to support hypothesis

1 - 2. The pain can't be caused by a strain or an overstretching of flexor carpi muscles because there are neither oedema nor swelling nor bruise so there isn't a damage of structure. With a strain or an overstretching the pain could be worse during the wrist extension because of the stretching of muscles. Furthermore the patient isn't in an analgesic position.

3. The pain is attributable to a contracture of flexor carpi muscles because it is aggravated by playing tennis during forehand, so during the wrist flexion and the flexor muscles activation.

4. The pain can't be caused by an epitrochleitis because of the localization of the pain that isn't near the epitrochlea.

5. We cannot totally exclude a wrist sprain. In fact the patient refers pain near wrist when he puts the hand on a table as he gets up from the chair. Probably there is a joint dysfunction between the bones of the carp.

Diagnosis

Flexor carpi muscles contracture with joint dysfunction of wrist bones.

Treatment and patient advice

The operator performs a deep tissue treatment on flexor carpi muscle, a general treatment on the internal muscle chain of upper limb and some articulate techniques on wrist bones.

Reflective content: how does this patient fit into OPS grid?

Tick if the patient will be useful for

A. COMMUNICATION AND PATIENT PARTNERSHIP ☑

Sub section number short reflection:

A1. During this observation I saw that the operator was particularly quiet, sure of himself and clear in communication with the patient.

A4. Every patient must give him or her consent and signs the informed consent before examination and treatment. In this way, the patient is always informs about who will perform the treatment and how the treatment will be performed.

B. KNOWLEDGE, SKILLS AND PERFORMANCE ☑

Sub section number short reflection:

B1, B2. During this observation I learnt how to apply osteopathic concepts on the upper limb and how to make a discriminating diagnosis between the different hypothesis with specific tests.

B4. I deepened the topic about treatment of upper limb.

C. SAFETY AND QUALITY IN PRACTICE ☑

Sub section number short reflection:

C1, C2. The operator was able to conduct a logical anamneses, a specific physical osteopathic examination, to make a right diagnosis and formulate a correct treatment plan.

D. PROFESSIONALISM ☑

Sub section number short reflection:

D6. Personal informations about the patient are always keep reserved in respect of patient’s privacy.

D11, D12, D13. All necessary steps were taken to promote public health basing on health and safety legislation.

Any Additional evidence ☒

Clinical log book 7

Date: November 2016

Observed ☑

Treated ☐

Patient front sheet included? ☒

Number: 7	Sex: male	Age: 50	Area treated: the whole body

Presentation

The patient has got Down Syndrome and he comes to us with his mother for a pain in right knee that is caused by a congenital patellar dislocation. This situation happens about twice a year with sudden pain in anterolateral area and inability to walk. The last time was on June 2016 and to this day it never happened but with some movements, the pain returns with oedema. His mother also asks if we could help him to have a general comfortable taking into consideration his syndrome.

Hypothesis

1. Inflammation of cartilage under the patellar

Red flags ☑

What and why? An important red flag is the laxity of ligaments that is congenital because of Down Syndrome. It's dangerous because the all joints are unstable, especially in the high cervical vertebrae.

Examinations to support hypothesis

1. The inflammation of cartilage under the patellar is caused by the lateral patellar dislocation which is congenital for Down Syndrome and laxity of ligaments.

Diagnosis

Inflammation of cartilage under the patellar

Treatment and patient advice

The treatment is based on general osteopathic techniques on the right lower limb and on the whole body. The operator cannot does direct and specific techniques because of the congenital laxity of ligaments. Than It would be better to send him to another medical figure to make specific stretching exercises.

Reflective content: how does this patient fit into OPS grid?

Tick if the patient will be useful for

A. COMMUNICATION AND PATIENT PARTNERSHIP ☑

Sub section number short reflection:

A1. During this observation I see how the operator spoke to the patient in a very simple and gentle way in order to permit him to understand what he was saying. I also appreciated how the operator had to adapt communication strategies to suit the specific needs of the patient during the treatment.

A2. The patient seemed to be a little worried because the were many students with white coat in the room. However the operator reassured him that we were all good people.

A3. The operator completely changed his approach in speaking with the patient. In this way the patient could understand what the operator said. In the case there were also patient's mother and the operator give her any types of informations about treatment.

A4. Every patient must give him or her consent and signs the informed consent before examination and treatment. In this way, the patient is always informs about who will perform the treatment and how the treatment will be performed.

A5. The operator worked in partnership especially with patient's mother in order to perform safely the best treatment for the patient.

A6. Patient's mother told that she brought the patient to make many different activities in order to improve the humor, to stimulate cognitive aspects and maintain a good physical motility. The operator congratulated and sustained this life style to increase patient's health.

B. KNOWLEDGE, SKILLS AND PERFORMANCE ☑

Sub section number short reflection:

B1. It has been very interesting see what an osteopath could do on a patient with Down Syndrome.

B2,B4. Thanks to this experience I learnt what are the anatomical alterations in a person with Down Syndrome because, after that observation, I made research on it.

B3. The operator recognised and worked within the limits or his competence. Indeed, in case of Down Syndrome there is a genetical alteration which cannot be changed.

C. SAFETY AND QUALITY IN PRACTICE ☑

Sub section number short reflection:

C1. The most interesting thing was that on this patient hasn't been necessary an accurate and specific evaluation because the best treatment was a general treatment practiced on the whole body.

C2. Basing on this observation, I think that the management of a patient with Down Syndrome is really difficult because the operator had to deliver a non-invasive treatment plan and had to change it if the patient doesn't tolerate it.

C3, C4. The operator undertook a lot in treating the patient in order to understand his condition and improved his health and was extremely polite and considerate with him.

C9. The operator was alway prepared to act quickly to help patients in case of any type of discomfort or snag.

D. PROFESSIONALISM ☑

Sub section number short reflection:

D1. In this observation I see that the operator took in consideration the cooperation with other medical figures like physiotherapist and educators.

D3. There were a lot of informations during the anamnesis, and the operator showed us how to catch the information and to analyse them.

D4,D5. The fact the patient had the Down Syndrome didn't prejudice patient's care.

D6. Personal informations about the patient are always keep reserved in respect of patient's privacy.

D7, D14. The operator explained with honesty the clinical situation of the patient to his mother and also specified osteopathy's limits.

D9. The patient and his mother talked about other healthcare professionals and the operator has never commented them in a negative way.

D11,D12,D13. All necessary steps were taken to promote public health basing on health and safety legislation.

Any Additional evidence ☑

Long Reflection 1

Page number:

Clinical log book 8

Date: April 2017

Observed ☐

Treated ☑

Patient front sheet included? ☑

Number: 8	Sex: female	Age: 58	Area treated: lumbar spine

Presentation

The patient is an office worker who practices homemade gymnastics and often uses bicycle. She refers lower lumbar bilateral pain and also central pain from nearly ten years. The bilateral one is a dull and continuous pain; the central one appears with minimal movements and it's like a sudden blade. The first pain improves with anti-inflammatory drugs and warmth; the second one gets better with rest and both with stretching. She also refers a bit of stiffness in the same region during the morning which improves in one hour.

Hypothesis

1. Bilateral sacroiliac joint disfunction

2. Degeneration of intervertebral disc in L4-L5 segment

3. Arthrosis of intervertebral L4-L5 joints

4. Contracture of quadratus lomborum

5. Ankylosing spondilitis

Red flags ☒

Examinations to support hypothesis

1. The pain can't be caused by a sacroiliac joint disfunction because it isn't located in that point, the patient often uses the bicycle but she doesn't refer pain during the bike ride and there isn't tenderness at the palpation in the sacroiliac joints.

2 - 3 - 4. The pain can be due to arthrosis of intervertebral L4-L5 joint with associated degeneration and inflammation of intervertebral disc in L4-L5 segment that involve in a contracture of quadratus lomborum. This because the bilateral and dull pain improves with warmth and NSAIDs, and also the palpation causes pain. The central one, indeed, doesn't improves with NSAIDs because the intervertebral disc is poorly vascolarized. Both the pains get better with stretching because she is able to give more liberty to the intervertebral joints and stretch the quadratus lomborum. She also refers stifness in the morning which is typical of arthrosis.

5. The pain can't be attributable to the Ankylosing spondilitis because there are not the systemic symptoms associated, it usually affects young people and the pain is nearly the same from too many years.

Diagnosis

Arthrosis of intervertebral L4-L5 joint with associated degeneration and inflammation of intervertebral disc in L4-L5 segment that involve in a contracture of quadratus lomborum.

Treatment and patient advice

I first perform general soft tissue techniques on the spine muscles, mostly in the lumbar region and gluteus. Then make multiple articulate techniques in the L3-L4-L5 intervertebral joints and also in the sacrum joints. Finally I have to do a specific intervertebral disc re-education with an abdominal manipulation associated.

I also advise my patient to practise stretching for the lower lumbar everyday.

Reflective content: how does this patient fit into OPS grid?

Tick if the patient will be useful for

A. COMMUNICATION AND PATIENT PARTNERSHIP ☑

Sub section number short reflection:

A1. It was my first patient and I was a little nervous, I should have been quieter during the conversation with the patient.

A3. When I advice my patient to practise stretching for the lower lumbar tract, I explained her the exercise in an easy way without difficult words, and I also showed her the exercises so she understood all the information.

A4. Every patient must give him or her consent and signs the informed consent before examination and treatment. In this way, the patient is always informs about who will perform the treatment and how the treatment will be performed.

A6. I suggested some exercise to the patient to support her in caring for herself to maintain the results after the treatment and improve her health.

B. KNOWLEDGE, SKILLS AND PERFORMANCE ☑

Sub section number short reflection:

B1, B2, B4. After the treatment of this first patient, I saw that my osteopathic knowledge wasn't enough and that I wasn't able to apply osteopathic concepts during the treatment. So I studied deepen the osteopathic principles and I made research on low back pain in order to improve my professional knowledge.

C. SAFETY AND QUALITY IN PRACTICE ☑

Sub section number short reflection:

C1. I didn't perform a complete and logical physical examination on the patient, so I asked to the tutor to help me and to suggest me an orderly lineup to follow when I made physical evaluation.

C2. The tutor helped me to plan the osteopathic treatment.

C8. I completed my patient's record promptly and the tutor checked it.

D. PROFESSIONALISM ?

Sub section number short reflection:

D2, D3. When the patient arrived, I had to record the informations about the pain and write all the data on the medical history, but I forgot to ask some important informations.

D6. Personal informations about the patient are always keep reserved in respect of patient's privacy.

D7. I was honest with the patient and I told her that it was my first day in clinic as practitioner. **D11, D12, D13.** All necessary steps were taken to promote public health basing on health and safety legislation. **D14.** I acted with integrity, honesty and sincerity because a lack of integrity in my practice could negatively affect patient care. I have not provided any misleading advertising or information about myself and my practice.
Any Additional evidence ☑ Reflective Journal 4 Page number:

FRONT SHEET

ICOM
INTERNATIONAL COLLEGE of OSTEOPATHIC MEDICINE

Cinisello Balsamo, 3/3/2017

STUDENTE ~~Jessica Munari~~ Federica Terzi Anno accademico 5°

SUPERVISORE Luca Rizzi MEDICO Poggio

Dati Paziente

COGNOME [redacted] NOME [redacted]

VIA [redacted] CAP ______ CITTA' [redacted]

RECAPITI: TEL ______ CELL [redacted] EMAIL ______

REFERENTE ______

ETA' 68 SESSO (F) M OCCUPAZIONE impiegata

Anamnesi Patologica Prossima

① LOMBARE: da 15 anni lombosacrale a fascia. Rigidità.
F. Allevianti: caldo
F. Aggravanti: cambio di stagione e ritorno da posizioni mantenute.
No irradiazione arti
Esordio improvviso acuto della durata di circa 1 settimana.

② CERVICALGIA: ++ dx da un annetto.
1 blocco acuto di 1 settimana
stessi fattori allevianti e aggravanti della lombalgia.

Clinical log book 9

Date: April 2017

Observed ☐

Treated ☑

Patient front sheet included? ☑

Number: 9	Sex: female	Age: 16	Area treated: abdomen and left lower limb

Presentation

The patient is a 16-year-old girl, a normal-weight student. She is asymptomatic and requires postural control and conservative treatment following medical diagnosis of scoliosis resulting from real hypometry of the left lower limb.

Hypothesis

1. Imbalance of the lateral postural scheme

Red flags ☒

Examinations to support hypothesis

1. Being an asymptomatic patient, a postural investigation is performed. Existing a real structured scoliotic problem, the priority postural scheme will be the lateral one.

Diagnosis

On physical examination, the patient presents an altered lateral scheme with priority in the lower left limb because it is shorter than the right one. On the anterior-posterior plane it is possible to notice an increase of the lumbar lordosis and thoracic kyphosis curves. This imbalance is due to an abnormal augmented suprapubic abdominal pressure caused by dysmenorrhea.

Treatment and patient advice

Techniques of integration of the suprapubic zone with the lumbar spine are performed. Manipulative techniques on the sacrum bone and the thoracic spine to increase its extension are added. Finally, muscular release of the postero-lateral muscular chain of the left lower limb is performed.

Reflective content: how does this patient fit into OPS grid?

Tick if the patient will be useful for

A. COMMUNICATION AND PATIENT PARTNERSHIP ☑

Sub section number short reflection:

A1. Being a minor girl I had to adapt my language so as not to make her feel embarrassed and not use inappropriate terms that could have been offended her.

A2. Unfortunately I did not listen to the patient's preferences and I did not ask what her preferences were regarding the presence of other students. Being a pretty shy girl, she felt uncomfortable in front of male students, and I was not able to figure it out. I am mortified for this, but thanks to this experience I will always ask the patient what his or her preferences are.

A4. Every patient must give him or her consent and signs the informed consent before examination and treatment. In this way, the patient is always informs about who will perform the treatment and how the treatment will be performed.

A6. Because the patient had a structured scoliosis diagnosed, I urged her to do the exercises at home for the spine that the orthopaedic had prescribed for her.

B. KNOWLEDGE, SKILLS AND PERFORMANCE ☑

Sub section number short reflection:

B1. Thanks to the treatments performed on this patient I understood how to integrate osteopathic concepts into an altered postural scheme caused by a structured scoliosis.

B2, B4. Since I did not have sufficient knowledge about the conservative treatment to be applied in case of scoliosis, I did some research to deepen it. Furthermore, the topic was also addressed during the Elective program and it was very useful to me.

B3. Osteopathy is not able to modify a structured scoliosis, but it can only help with a conservative management of the consequences.

C. SAFETY AND QUALITY IN PRACTICE ☑

Sub section number short reflection:

C1, C2. I was able to perform a proper osteopathic evaluation and to formulate a treatment plan, focusing on the altered lateral posture.

C4, C6. I haven't been sufficiently considerate towards my patient because I haven't been able to understand and respect her discomfort of being observed by a male student.

C8. I completed my patient's record promptly and the tutor checked it.

D. PROFESSIONALISM ☑

Sub section number short reflection:

D6. Personal informations about the patient are always keep reserved in respect of patient's privacy.

D11, D12, D13. All necessary steps were taken to promote public health basing on health and safety legislation.

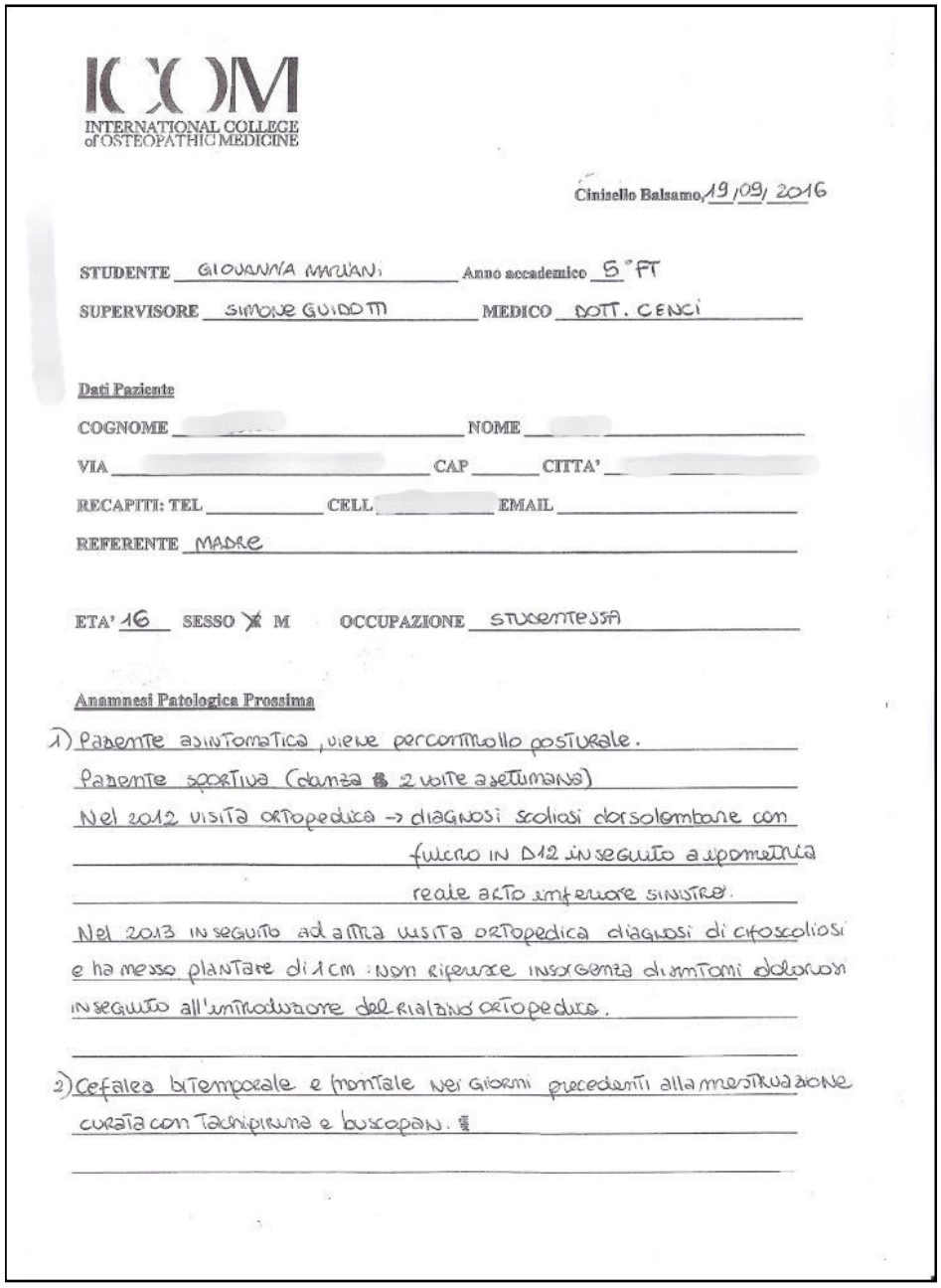
D14. I acted with integrity, honesty and sincerity because a lack of integrity in my practice could negatively affect patient care. I have not provided any misleading advertising or information about myself and my practice.

Any Additional evidence ☑

Reflective Journal 5

Page number:

FRONT SHEET



ICOM
INTERNATIONAL COLLEGE of OSTEOPATHIC MEDICINE

Cinisello Balsamo, 19/09/2016

STUDENTE GIOVANNA MARIANI Anno accademico 5° FT

SUPERVISORE SIMONE GUIDOTTI MEDICO DOTT. CENCI

Dati Paziente

COGNOME [redacted] NOME [redacted]

VIA [redacted] CAP [redacted] CITTA' [redacted]

RECAPITI: TEL [redacted] CELL [redacted] EMAIL [redacted]

REFERENTE MADRE

ETA' 16 SESSO X F M OCCUPAZIONE STUDENTESSA

Anamnesi Patologica Prossima

1) Paziente asintomatica, viene per controllo posturale.
Paziente sportiva (danza 2 volte a settimana)
Nel 2012 visita ortopedica → diagnosi scoliosi dorsolombare con fulcro in D12 in seguito a ipomielia reale arto inferiore sinistro.
Nel 2013 in seguito ad altra visita ortopedica diagnosi di cifoscoliosi e ha messo plantare di 1 cm: non riferisce insorgenza di sintomi dolorosi in seguito all'introduzione del rialzo ortopedico.

2) Cefalea bitemporale e frontale nei giorni precedenti alla mestruazione curata con Tachipirina e buscopan.

Clinical log book 10

Date: May 2017

Observed ☐

Treated ☑

Patient front sheet included? ☑

Number: 10	Sex: male	Age: 53	Area treated: thoracic spine and right foot

Presentation

The patient is out of work and overweight. He doesn't complaint any kind of pain actually; he suffered from a left shoulder pain due to a contracture and impingement of supraspinatus muscle two years ago. This contracture was based on an altered laterale postural scheme. He is asymptomatic since 6 months.

Hypothesis

1. Altered posture

Red flags ☒

Examinations to support hypothesis

1. The patient is asymptomatic since many months and his posture is significantly improved with osteopathic treatment.

Diagnosis

The patient presents an imbalance in both the anterior-posterior and lateral schemes. On the anterior-posterior plane, a structured and large thoracic kyphosis and a very prominent abdomen with an increased abdominal pressure are visible. On the lateral level there is a first pelvic degree of the pelvis with priority descent from the cervico-dorsal area of the spine and secondary in the dorsal-lumbar tract. The priority is convex left while the secondary is a convex right curve related to the lower right limb.

Treatment and patient advice

A general soft tissue is performed on the back with combined articulatory techniques in the cervico-dorsal and dorso-lumbar areas. The right foot is treated with inhibition of the plantar fascia and manipulative techniques on the midfoot. Finally, a release of the posterior muscle chain of the right lower limb is performed.

Reflective content: how does this patient fit into OPS grid?

Tick if the patient will be useful for

A. COMMUNICATION AND PATIENT PARTNERSHIP ☑

Sub section number short reflection:

A4. Every patient must give him or her consent and signs the informed consent before examination and treatment. In this way, the patient is always informs about who will perform the treatment and how the treatment will be performed.

A6. This patient has a very bad dermatitis on the whole back and on the legs. I always ask him if he continues to treat the dermatitis in order to support him in caring for himself.

B. KNOWLEDGE, SKILLS AND PERFORMANCE ☑

Sub section number short reflection:

B1. On this patient it's important understand osteopathic principles to find the priority in the posture of the patient and treat it to improve and maintain the corrections.

C. SAFETY AND QUALITY IN PRACTICE ☑

Sub section number short reflection:

C1, C2. I have performed a complete physical examination on patient to find the priority on his alterate posture and I've planned a logical treatment to correct all the dysfunctions.

C8. I completed my patient's record promptly and the tutor checked it.

C9. Since the patient is overweight, he is struggling to move and I am always ready to act quickly to help him avoid falling from the couch and getting hurt.

D. PROFESSIONALISM ☑

Sub section number short reflection:

D6. Personal informations about the patient are always keep reserved in respect of patient's privacy.

D11,D12,D13. All necessary steps were taken to promote public health basing on health and safety legislation.

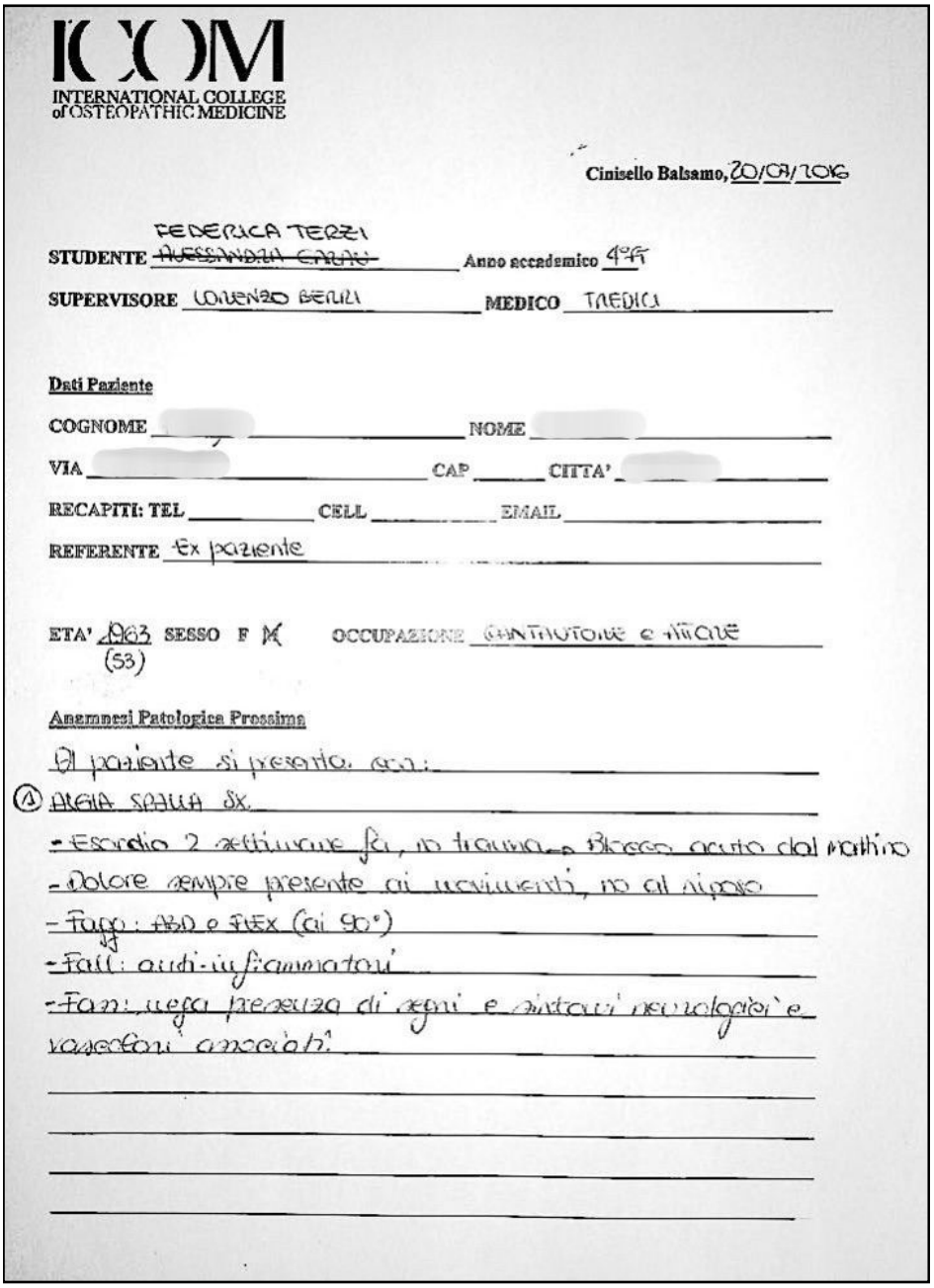
D14. I acted with integrity, honesty and sincerity because a lack of integrity in my practice could negatively affect patient care. I have not provided any misleading advertising or information about myself and my practice.

Any Additional evidence ☑

Reflective Journal 6

Page number:

FRONT SHEET



ICOM
INTERNATIONAL COLLEGE of OSTEOPATHIC MEDICINE

Cinisello Balsamo, 20/09/2016

STUDENTE ~~ALESSANDRA CARAU~~ FEDERICA TERZI Anno accademico 4°A

SUPERVISORE LORENZO BERLI MEDICO TREDICI

Dati Paziente

COGNOME [redacted] NOME [redacted]

VIA [redacted] CAP ____ CITTA' [redacted]

RECAPITI: TEL ____ CELL ____ EMAIL ____

REFERENTE ex paziente

ETA' 1963 (53) SESSO F M OCCUPAZIONE CANTANTE e MAMMA

Anamnesi Patologica Prossima

Il paziente si presenta con:

(A) ANCA SPALLA SX.

- Esordio 2 settimane fa, no trauma → Blocco acuto dal mattino
- Dolore sempre presente ai movimenti, no al riposo
- Fugo: ABD e FLEX (ai 90°)
- Fall: anti-infiammatori
- Fam: nega presenza di segni e sintomi neurologici e vascolari associati

Clinical log book 11

Date: May 2017

Observed ☐

Treated ☑

Patient front sheet included? □

Number: 11	Sex: female	Age: 50	Area treated: front of the neck

Presentation

The patient is a 50-year-old woman, slightly overweight, employed. She comes to the ICOM clinic for a pain referred to the lower part of the mandible that arose a week earlier while working. The pain has arisen gradually and today only a nuisance has remained. This pain is pungent and worsens with the extension of the head because she feels to stretch the entire front of the neck. It improves wearing the scarf and with anti-inflammatory drugs. Even when she swallows she feels a central pang in her neck and has difficulty swallowing. She has no night pain and has no pain when she coughs or sneezes.

Hypothesis

1. Contracture of overioid muscles
2. Herpes zoster
3. Hyoid bone dysfunction
4. Tooth abscess
5. Esophageal diverticulum

Red flags ☒

Examinations to support hypothesis

1. This hypothesis is very probable because a contracture of muscle tissue improves with heat and with antinflammatory drugs. Indeed, the patient reports that bringing the scarf this pain improves. She also reports feeling a strain on the front of her neck when she brings her head back. And finally, after a week the pain is almost solved, indicating the timing of muscle tissue.
2. The herpes zoster in this area would have attack the mandibular branch of the trigeminal nerve. However, this hypothesis is excluded because there are no associated signs or symptoms. Furthermore, the symptomatology is bilateral and it is rare for herpes zoster to affect both the right and the left part at the same time.
3. This hypothesis is taken into account because during the swallowing the hyoid bone should move upwards, but the patient struggles to do it and feels a central pin. Furthermore, on the palpation the hyoid bone is without mobility.
4. The presence of a dental abscess is excluded because the pain is widespread at both mandibular branches. In addition, the patient has no pain in chewing, has no blood loss from the gums and there is no swelling.

5. An esophageal diverticulum at the neck level could be justified by dysphagia and punctiform pain in swallowing. In addition, halitosis may be present due to the stagnation of food in the diverticulum. This hypothesis is however excluded because the pain is relieved by anti-inflammatories and heat, and from one week to the present the pain has almost been resolved, while an esophageal diverticulum would still be present.

Diagnosis

Acute contracture of the overioid muscles with dysfunction of the hyoid bone.

Treatment and patient advice

Fascial rebalance of the cervical fascia. Functional inhibition of the overioid and subioid musculature. Correlation between hyoid bone and tongue to increase mobility. Articulatory technique on K1-K2. HVLA in the cervico-dorsal tract.

Reflective content: how does this patient fit into OPS grid?

Tick if the patient will be useful for

A. COMMUNICATION AND PATIENT PARTNERSHIP ☑

Sub section number short reflection:

A2. The patient was very worried about this new sudden pain, so I tried to listen to her and then to reassure her by explaining that it was nothing serious.

A4. Every patient must give him or her consent and signs the informed consent before examination and treatment. In this way, the patient is always informs about who will perform the treatment and how the treatment will be performed.

B. KNOWLEDGE, SKILLS AND PERFORMANCE ☑

Sub section number short reflection:

B1, B2, B4. I had difficulty understanding which tissue was painful. The tutor helped me to perform a correct physical examination. However, since my knowledge about it was not sufficient, I examined some of the hypotheses put in the differential diagnosis.

C. SAFETY AND QUALITY IN PRACTICE ☑

Sub section number short reflection:

C1, C2. Once I understood what the dysfunction was, I was able to come up with a complete treatment plan to reduce the patient's symptoms.

C6. This patient felt uncomfortable in the presence of male students. Therefore, respecting her preferences and her dignity, I never let a male student come in to observe the visit.

C8. I completed my patient’s record promptly and the tutor checked it.

D. PROFESSIONALISM ☑

Sub section number short reflection:

D6. Personal informations about the patient are always keep reserved in respect of patient’s privacy.

D11, D12, D13. All necessary steps were taken to promote public health basing on health and safety legislation. **D14.** I acted with integrity, honesty and sincerity because a lack of integrity in my practice could negatively affect patient care. I have not provided any misleading advertising or information about myself and my practice.
Any Additional evidence ☑ Reflective Journal 7 Page number:

Clinical log book 12

Date: May 2017

Observed ☐

Treated ☑

Patient front sheet included? ☑

Number: 12	Sex: female	Age: 51	Area treated: c-section scar

Presentation

The patient is a 51-year-old woman, normal-weight, employed. She comes to the ICOM clinic for:

- a dorsalgia and cervicalgia bilateral combined with helmet headache which have been present for about 14 years. These symptoms occur twice a week and in the order of onset, the dorsalgia first occurs and finally the headache is the most disabling and strong pain. They arise gradually and without apparent cause and the headache lasts for about 3 days. The symptoms all improve with heat and anti-inflammatory and get worse with neck movement.
- a heaviness in the lower limbs referred almost every evening according to the intensity of the work carried out during the day.

The patient underwent two caesarean sections.

Hypothesis

1. Ankylosing spondylitis
2. Myotensive headache
3. Cluster headache
4. Contracture of the paravertebral muscles
5. Difficulty in drainage of the lower limbs

Red flags ☒

Examinations to support hypothesis

1. This hypothesis is excluded because the pain is not associated with stiffness and the symptom has been present for 14 years. It also improves with heat, while a rheumatic disease would improve with cold.

2-3. The headache is a cervicogenic myotensive headache as it improves with heat, is associated with neck movements, is bilateral and takes the whole skull. A cluster headache is excluded because it would affect only half the skull and would concentrate in the occipital area and at the ipsilateral eye. Furthermore, prodromal signs, paresthesia of the scalp and tearing of the eye are not associated. Finally, the pain that the patient reports is not a pulsating type (vascular tissue index).

4. This hypothesis is confirmed by palpation which is painful. Furthermore, pain improves with heat and with anti-inflammatories drugs.

5. From the semeiological point of view in the lower limbs there is no lymphedema or varicose veins. The skin of the legs and the temperature are normal and homogeneous. Furthermore, the arterial pulses are all valid and normosfigmic. The hypothesis of light difficulty in drainage of the lower limbs is confirmed with the combination of a general muscular fatigue. In addition, the patient underwent two cesarean sections with scar's adhesions that altered the muscles of the small pelvis.

Diagnosis

Chronic contracture of the dorsal and cervical paravertebral muscles. Chronic contracture of the suboccipital musculature that causes myotensive headache. Difficulty of drainage from the lower limbs caused by an alteration of the pelvic floor following the two cesarean sections.

Treatment and patient advice

On this patient, scar techniques were carried out in correlation with the sacrum in such a way as to reduce adhesions. The pelvic floor muscles, the diaphragm and the paravertebral dorsal, cervical and suboccipital muscles were treated. Finally, a pumping technique for drainage to the lower limbs was performed.

Reflective content: how does this patient fit into OPS grid?

Tick if the patient will be useful for

A. COMMUNICATION AND PATIENT PARTNERSHIP ☑

Sub section number short reflection:

A2. The patient was very worried about the symptom that referred to the lower limbs. So although it was not a serious thing, I listened to her very carefully giving her the importance she deserved.

A4. Every patient must give him or her consent and signs the informed consent before examination and treatment. In this way, the patient is always informs about who will perform the treatment and how the treatment will be performed.

B. KNOWLEDGE, SKILLS AND PERFORMANCE ☑

Sub section number short reflection:

B1. In this case the tutor made me understand very clearly the osteopathic concepts to be applied in case of caesarean sectional scar

B4. To deepen the subject and update my knowledge, I bought a book on the treatment of scars that was also very useful for the treatment of other patients.

C. SAFETY AND QUALITY IN PRACTICE ☑

Sub section number short reflection:

C1, C2. The tutor's help was essential to perform a correct osteopathic evaluation sufficiently accurate to formulating an osteopathic treatment plan focused on the treatment of scar and small pelvis.

C8. I completed my patient’s record promptly and the tutor checked it.

D. PROFESSIONALISM ☑

Sub section number short reflection:

D6. Personal informations about the patient are always keep reserved in respect of patient's privacy.

D9. Although the c-scar was full of palpable internal adhesions, indicating an incorrect suture method, I did not allow myself to make negative comments about the surgeon who had operated her.

D11, D12, D13. All necessary steps were taken to promote public health basing on health and safety legislation.

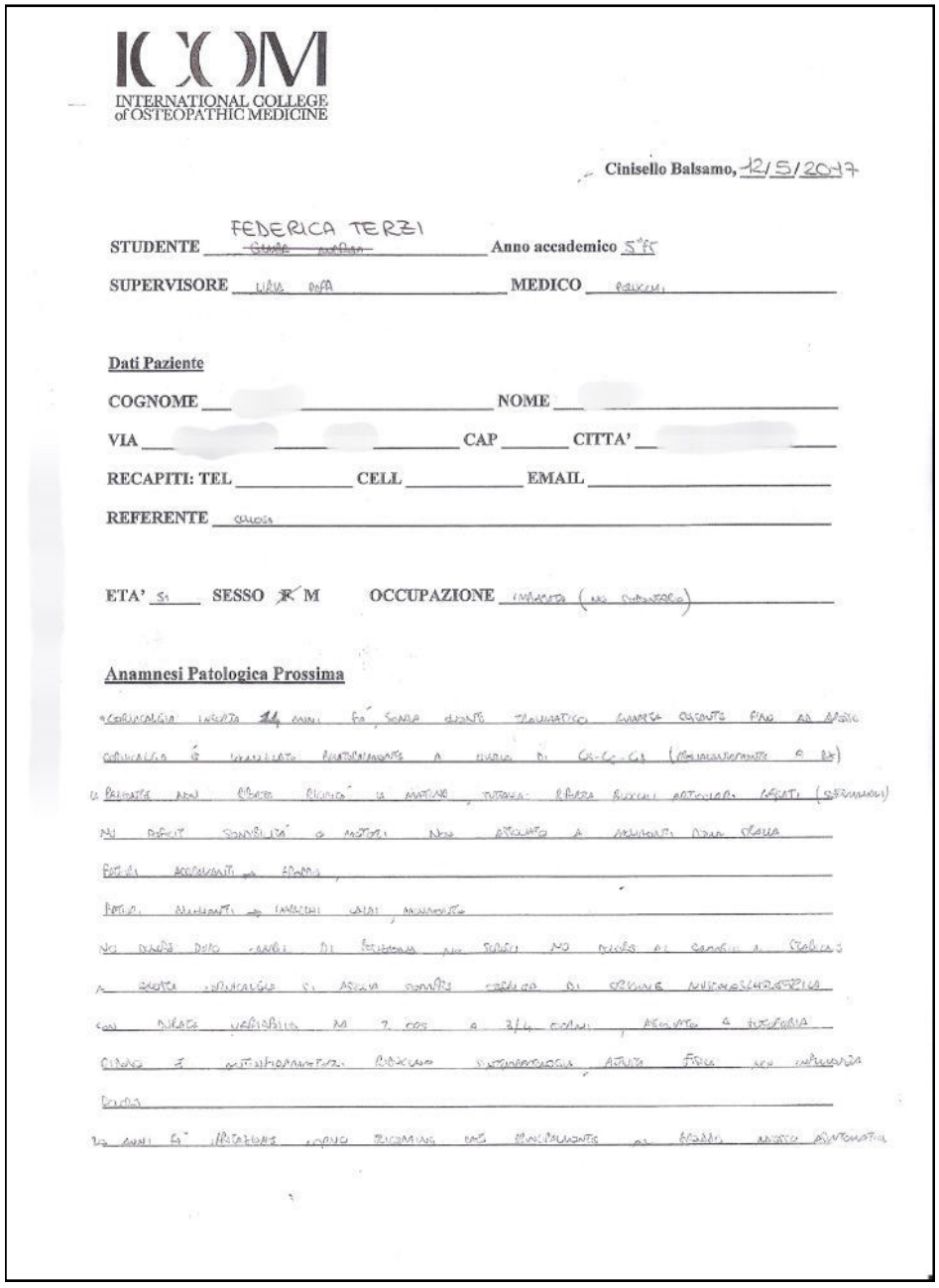
D14. I acted with integrity, honesty and sincerity because a lack of integrity in my practice could negatively affect patient care. I have not provided any misleading advertising or information about myself and my practice.

Any Additional evidence ☑

Reflective Journal 8

Page number:

FRONT SHEET



ICOM
INTERNATIONAL COLLEGE of OSTEOPATHIC MEDICINE

Cinisello Balsamo, 12/5/2017

STUDENTE FEDERICA TERZI Anno accademico 5°

SUPERVISORE [illegible] MEDICO [illegible]

Dati Paziente

COGNOME [illegible] NOME [illegible]

VIA [illegible] CAP [illegible] CITTA' [illegible]

RECAPITI: TEL [illegible] CELL [illegible] EMAIL [illegible]

REFERENTE [illegible]

ETA' 51 SESSO F M OCCUPAZIONE [illegible]

Anamnesi Patologica Prossima

[illegible]

Clinical log book 13

Date: October 2017

Observed ☑

Treated ☐

Patient front sheet included? ☑

Number: 13	Sex: female	Age: 49	Area treated: sacrum and occipital

Presentation

The patient is an employee with low back pain on right side with irradiation in the thigh's lateral part for five years. It improves only with NSAID and heat. She also presents hemiparesis in all body on right side due to birth with forceps. There is a mono lateral (right) motor nerve's deficit with due tu left cerebropathy following birth with distal delivery. She cannot bring heavy bag with right arm because of pain. Sometimes the arm becomes spastic and she cannot move it. She has not stability during walking because she cannot totally move her lower right limb. She also has less feeling in it. For these reasons she often fall down. She takes antidepressants drug from 10 years after her child's death, and anti epileptic drug from 17 years after child's birth. She reports having undergone arthrodesis at the right ankle as a child.

Hypothesis

1. Quadratus lomborum's contracture

2. Cronic contracture of deep paravertebral muscules

3. Meralgia paraesthetica (Bernhardt–Roth syndrome)

4. Radiculopathy of L4

Red flags ☑

What and why? Antidepressant drugs could cause side effects on nervous system and cardiac system. For this reason the operator cannot praticate direct strong techniques. Furthermore, the patient is epileptic so the operator must be very careful to avoid outbreaks of seizures.

Examinations to support hypothesis

1-2. This hypothesis is validated by the fact that the symptom changes according to the movements, it improves with the anti-inflammatories and with the heat. In addition to palpation the muscles are contracted and painful.

3. This hypothesis is excluded because there is no pain on the palpation of the inguinal ligament and the Tinel Test is negative. Furthermore, there is no alteration of the sensibility in the anterior portion of the thigh.

4. This hypothesis is excluded because the neurological examination is negative in sensitivity, reflexes and strength. Furthermore, the symptomatology does not occur with the Closure Test of the intervertebral foramina.

Diagnosis

Contraction of the superficial and deep lumbar musculature with propagation of muscular pain in the right limb. This unilateral contracture is caused by an alteration of the lateral postural scheme maintained by the right spastic hemiparesis.

Treatment and patient advice

On this patient a very gentle cranio-sacral therapy is performed with the addition of diaphragms' treatment on first visit. Subsequently, the lateral postural scheme is treated and rebalanced with GOT techniques performed on the lower right limb and on the spine.

Reflective content: how does this patient fit into OPS grid?

Tick if the patient will be useful for

A. COMMUNICATION AND PATIENT PARTNERSHIP ☑

Sub section number short reflection:

A2. In this visit I only observed the anamnesis phase. Then the patient preferred stay alone with the operator and the tutor. I had to respect her preferences and I left the clinic.

A4. Every patient must give him or her consent and signs the informed consent before examination and treatment. In this way, the patient is always informs about who will perform the treatment and how the treatment will be performed.

A6. This patient stopped taking care of herself when her child had got cancer. She became depressed and lost faith in every physicians. For these reasons she ceased practice physiotherapy. The operator and the tutor supported her in caring on herself to improve her own health.

B. KNOWLEDGE, SKILLS AND PERFORMANCE ☑

Sub section number short reflection:

B3. This patient has a mono lateral motor nerve’s lesion. Manual therapy couldn’t change this condition and the osteopath must recognise the limits of its training and competence.

B4. I personally wanted to deepen the topic concerning brain injuries following a difficult birth because I did not have adequate knowledge about it.

C. SAFETY AND QUALITY IN PRACTICE ☑

Sub section number short reflection:

C3. The operator and the tutor were extremely considerate of the patient and tried to understand her physical and psychological condition.

C4, C6. I respected patient’s modesty because she was ashamed to undress in front of many students. So, I left the clinic.

D. PROFESSIONALISM ☑

Sub section number short reflection:

D1. The tutor and the doctor advised the patient to resume rehabilitative physiotherapy at a physiotherapy center in parallel with osteopathic treatments.

D6. Personal informations about the patient are always keep reserved in respect of patient’s privacy. **D9.** Although the patient's physical problem was caused by an error of the obstetrician during her birth, no one made negative comments by offending the doctor in question. **D11, D12, D13.** All necessary steps were taken to promote public health basing on health and safety legislation.
Any Additional evidence ☑ Reflective Journal 9 Page number:

FRONT SHEET

ICOM EDUCATIONAL

Cinisello Balsamo, 23/10/17

STUDENTE CARBONE SOSIO Anno accademico VFT

SUPERVISORE FICA MEDICO CENCI

Dati Paziente

COGNOME [redacted] NOME [redacted]

VIA [redacted] CAP [redacted] CITTA' [redacted]

RECAPITI: TEL [redacted] CELL [redacted] EMAIL [redacted]

REFERENTE Comune

ETA' 49 SESSO (F) M OCCUPAZIONE IMPIEGATA

Anamnesi Patologica Prossima

Lombalgia a fascia + dolore ad arto superiore DX e inferiore DX
Situazioni presenti da molti anni
Causa: emiparesi DX da parto distocico
emiparesi spastica con ipotrofia e ipertono spastico
In questo quadro di encefalopatia SX si evince
una notevole dilatazione del ventricolo laterale SX
potrebbe essere la causa delle crisi epilettiche che la
pz riferisce di avere post gravidanza e parto (1999)

Clinical log book 14

Date: October 2017

Observed ☐

Treated ☑

Patient front sheet included? ☑

Number: 14	Sex: male	Age: 34	Area treated: right foot

Presentation

The patient is a 34-year-old man, normal-weight, employee and footballer. He comes to ICOM clinic complaining a pain in his right ankle following a sprain of the ankle in eversion occurred one week ago. After the trauma there was a small purple edema, but it was improved with ice and anti-inflammatory drugs. At the time of the visit remains only an annoyance and the edema has reabsorbed. In addition, after the trauma, a pungent pain in the posterior part of the heel and a pain in the final part of the Achilles tendon have returned. This pain was resolved a year ago following some cycles of shock waves because it was due to a calcaneal spine diagnosed several years before.

Hypothesis

1. Sprain of the lateral ligaments of the ankle

2. Strain of peroneal muscles

3. Strain of the gastrocnemius muscle

4. Lesion of the peroneal muscles tendons

5. Subtalar joint dysfunction

6. Fracture of the peroneal malleolus

Red flags ☑

Among the hypotheses was the fracture of the peroneal malleolus which is a redflag because in the case of suspected fracture it would be necessary to send the patient immediately to the first aid to make an x-ray.

Examinations to support hypothesis

1-2-3. These hypotheses are true all three because on palpation the peroneal muscles and the gastrocnemius are painful and they are in antalgic contracture. In addition, muscle activation does not cause pain in the ankle. Distortion caused inflammation of the joint capsule with stretching of the laterale ligament without serious injury. In fact, with the ice and the anti-inflammatories the symptoms have improved within a few days.

4. If there had been a rupture or injury of the peroneal tendons, the edema would have been much more evident and the symptoms would not have passed in so few days. Furthermore, pain would be evoked by palpation and by the activation of peroneal muscles. So, this hypothesis is excluded.

5. This hypothesis is taken into account because during the articular test, the range of movement of the subtalar joint is almost nil and the articulation results to be remarkably rigid.

6. This hypothesis is excluded because the pain would not have disappeared with the anti-inflammatories and would have lasted longer. Furthermore, the Tinel Test on the peroneal malleolus is negative.

Diagnosis

Sprain of the joint capsule and strain of peroneal and gastrocnemius muscles in antalgic contracture.

Treatment and patient advice

On this patient, muscular inhibition techniques on the gastrocnemius and peroneal muscles, drainage techniques to promote the resorption of edema, an HVLA technique on the subtalar joint and a BLT technique on the ankle are performed.

Reflective content: how does this patient fit into OPS grid?

Tick if the patient will be useful for

A. COMMUNICATION AND PATIENT PARTNERSHIP ☑

Sub section number short reflection:

A1. Having been my first visit, I was not able to change my communication strategies to adapt to the patient, who did not have much time available and had not been made aware of the way in which the visit was carried out. For these reasons, the patient has been annoyed both with me and with the tutor and has not returned to the following appointments.

A4. Every patient must give him or her consent and signs the informed consent before examination and treatment. In this way, the patient is always informs about who will perform the treatment and how the treatment will be performed.

A6. Although the patient had little time available, the tutor and I tried to encourage him to come to appointments to be treated and solve his symptoms and improve his state of health.

B. KNOWLEDGE, SKILLS AND PERFORMANCE ☑

Sub section number short reflection:

B1. Thanks to the tutor I was able to understand the osteopathic concepts and apply them appropriately during the patient's visit.

C. SAFETY AND QUALITY IN PRACTICE ☑

Sub section number short reflection:

C1, C2. Together with the tutor I performed a complete osteopathic assessment based on the patient's symptom and trauma, in order to plan the most suitable osteopathic treatment for him.

C4. Although the patient was angry at me, I was always polite to him during the entire duration of the visit.

C8. I completed my patient’s record promptly and the tutor checked it.

D. PROFESSIONALISM ☑

Sub section number short reflection:

D6. Personal informations about the patient are always keep reserved in respect of patient's privacy.

D11, D12, D13. All necessary steps were taken to promote public health basing on health and safety legislation.

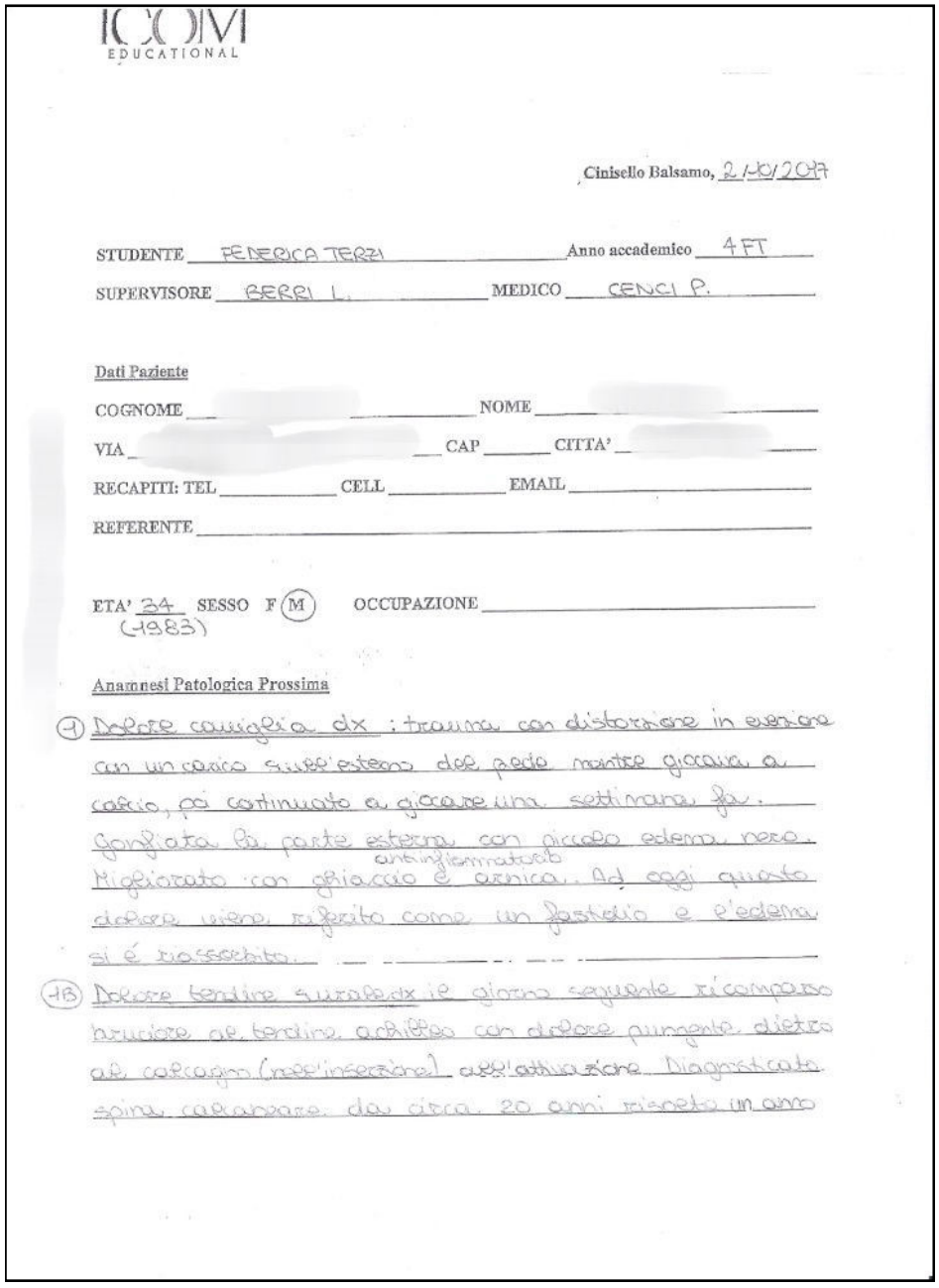
D14. I acted with integrity, honesty and sincerity because a lack of integrity in my practice could negatively affect patient care. I have not provided any misleading advertising or information about myself and my practice.

Any Additional evidence ☑

Reflective Journal 10

Page number:

FRONT SHEET



ICOM EDUCATIONAL

Cinisello Balsamo, 2/10/2017

STUDENTE FEDERICA TERZI Anno accademico 4FT

SUPERVISORE BERRI L. MEDICO CENCI P.

Dati Paziente

COGNOME [redacted] NOME [redacted]

VIA [redacted] CAP [redacted] CITTA' [redacted]

RECAPITI: TEL [redacted] CELL [redacted] EMAIL [redacted]

REFERENTE [redacted]

ETA' 34 (1983) SESSO F (M) OCCUPAZIONE [redacted]

Anamnesi Patologica Prossima

(1) Dolore caviglia dx: trauma con distorsione in eversione con un carico sull'esterno del piede mentre giocava a calcio, poi continuato a giocare una settimana fa. Gonfiato la parte esterna con piccolo edema, nero. Migliorato con ghiaccio e arnica (antinfiammatorio). Ad oggi questo dolore viene riferito come un fastidio e l'edema si è riassorbito.

(2B) Dolore tendine surale dx il giorno seguente ricomparso bruciore al tendine, achilleo con dolore pungente dietro al calcagno (inserzione) all'attivazione. Diagnosticato spina calcaneare da circa 20 anni risolto in anno

Clinical log book 15

Date: November 2017

Observed ☐

Treated ☑

Patient front sheet included? ☑

Number: 15	Sex: female	Age: 48	Area treated: T4 and right psoas

Presentation

The patient is a 48-year-old woman, normal-weight, restorer. Come to ICOM clinic for a pain in the right groin which has been present since about 1 year and a half and has appeared without apparent cause. This pain is described as a pin when she crosses her legs or when she sits in the car. She also reports that she feels a cord in the groin when she stends up from a sitting position.

Hypothesis

1. Osteoarthritis of the hip
2. Contracture of the psoas muscle
3. Sacroiliitis
4. Impingement of the hip

Red flags ☒

Examinations to support hypothesis

1. This hypothesis is excluded because the pain does not worsen when walking, it is never associated with stiffness and there is no loss of articular range of movement. In addition, the Faber Test and the Scour Test were performed and both were negative.
2. This hypothesis is accepted because on palpation the right psoas muscle is particularly painful and very contracted in several points of its course. The Thomas Test was also positive.
3. A sacroiliitis was taken into consideration as the pain get worse being sitting and is present in the groin area. However there is no pain in the posterior area even at the palpation. Furthermore, the Faber Test, the Compression Test and the Distraction Test are negative.
4. This hypothesis was excluded because the Faddir Test, the Mfir Test, the Mfer Test and the Fitzgerald Test were all negative

Diagnosis

Chronic contracture of the right psoas muscle

Treatment and patient advice

A myofascial release of the thoracic-abdominal fascia, a general soft tissue on the back, some articulatory techniques in T4 correlating with the mediastinum are performed. Then a BLT technique is made on the right inguinal ligament and an inhibition of the psoas muscle both in the abdominal portion and in the insertion is done.

Reflective content: how does this patient fit into OPS grid?

Tick if the patient will be useful for

A. COMMUNICATION AND PATIENT PARTNERSHIP ☑

Sub section number short reflection:

A1. During the interview with this patient, I was able to use my well-developed communication skills during other visits previously performed with other patients.

A4. Every patient must give him or her consent and signs the informed consent before examination and treatment. In this way, the patient is always informs about who will perform the treatment and how the treatment will be performed.

B. KNOWLEDGE, SKILLS AND PERFORMANCE ☑

Sub section number short reflection:

B1. Thanks to the tutor I was able to understand the osteopathic concepts and apply them appropriately during the patient's visit.

B2, B4. Thanks to an extra-curricular course on the inguinal region that I attended in November, I deepened and updated my knowledge about the treatment of psoas muscle throughout its course.

C. SAFETY AND QUALITY IN PRACTICE ☑

Sub section number short reflection:

C1, C2. I was able to perform only part of the osteopathic examination because the tutor helped me to find the right priority. However, together we performed a complete osteopathic evaluation and then managed to formulate and put into practice an excellent osteopathic treatment plan.

C8. I completed my patient’s record promptly and the tutor checked it.

D. PROFESSIONALISM ☑

Sub section number short reflection:

D6. Personal informations about the patient are always keep reserved in respect of patient’s privacy.

D11, D12, D13. All necessary steps were taken to promote public health basing on health and safety legislation.

D14. I acted with integrity, honesty and sincerity because a lack of integrity in my practice could negatively affect patient care. I have not provided any misleading advertising or information about myself and my practice.

Any Additional evidence ☑

Reflective Journal 11

Long Reflection 2

Page number:

FRONT SHEET

ICOM EDUCATIONAL

Cinisello Balsamo, 2/11/17

STUDENTE FEDERICA TERZI Anno accademico 4 FT

SUPERVISORE FENAROLI C. MEDICO TREDICI

Dati Paziente

COGNOME [redacted] NOME [redacted]

VIA [redacted] CAP [redacted] CITTA' [redacted]

RECAPITI: TEL [redacted] CELL [redacted] EMAIL [redacted]

REFERENTE COLLEGA DI LAVORO

ETA' 48 (1969) SESSO F M OCCUPAZIONE IMPIEGATA E RESTAURATRICE
SPORT: PILATES, GINNASTICA

Anamnesi Patologica Prossima

① Dolore anca dx: 3 anni fa, mentre correva fa aiuto blocco dell'anca (no dolore, no scrocchi articolari) doveva trascinarsi la gamba (non riusciva a fare appoggiare d'anca per fare il passo). È successo alla sera, la mattina dopo non avevo più nulla. Luglio 17 è ricapitato uguale. Da 1 anno ½ fa fastidio in zona inguinale quando sto seduta o quando accavallo la gamba e quando fa qualche movimento durante ginnastica; nel rialzarsi sente tirare a livello inguinale. No formicolii

② Dolore DX: insorgenza progressiva senza causa

Clinical log book 16

Date: December 2017

Observed ☐

Treated ☑

Patient front sheet included? ☑

Number: 16	Sex: male	Age: 55	Area treated: not treated

Presentation

The patient is a merchant and overweight. He complaints a bilateral pain in both lower limbs, especially in legs, calves and feet. It isn't in a specific area, in fact it's a migrant pain which changes always the position. He describes this pain as a cramp and burning, but there are any cutaneous alterations; furthermore the patient made a doppler ultrasound in lower limbs and it was negative. This pain started gradually one year ago. The symptomatology appears when he walks for less then 7 minutes or when he stands queued. He must sit down for one minute, then the pain disappeared and restarts in the same manner. He doesn't refer urinary disorder.

Hypothesis

1. Neurogenic claudication
2. Vascular claudication
3. Cauda equina syndrome
4. Disc herniation L5-S1
5. Anterolisthesis L5-S1

Red flags ☑

What and why? The cauda equina syndrome is a compression of the cauda equina in lumbar spine and provokes bilateral neurological symptoms in legs and in the panty area with urinary disorders.

Examinations to support hypothesis

1. The symptoms appear regularly during walking or standing and finish always when the patient sits down.
2. This hypothesis has been excluded because there aren't cutaneous alterations in terms of temperature, color and texture. Furthermore, ultrasonography was negative.
3. Cauda equina syndrome has been excluded because there are neither neurological symptoms in the panty area nor urinary disorder.
4. Neurological examination has been performed to evaluate this hypothesis and it was positive.
5. Orthopaedic test for instability of lumbar spine has been performed and it was positive.

Diagnosis

Neurogenic claudication due to bilateral disc herniation L5-S1 and anterolisthesis of L5-S1 with compression of spinal cord.

Treatment and patient advice

The patient has been postponed by the orthopaedic since a lumbar spine stenosis has been suspected. For this reason it was not treated on the first visit.

Reflective content: how does this patient fit into OPS grid?

Tick if the patient will be useful for

A. COMMUNICATION AND PATIENT PARTNERSHIP ☑

Sub section number short reflection:

A1,A2. The patient was extremely worried about his condition, so I always listen to him and I change my communication strategies to suit to him. Furthermore, the patient is Egyptian and I must make myself understood and try to understand him.

A3. I use easy word when I give him the informations about treatment.

A4. Every patient must give him or her consent and signs the informed consent before examination and treatment. In this way, the patient is always informs about who will perform the treatment and how the treatment will be performed.

A5,A6. He's overweight and he smokes, so I tried to convince him to loose weight and stop smoking.

B. KNOWLEDGE, SKILLS AND PERFORMANCE ☑

Sub section number short reflection:

B1. The tutor helped me to apply osteopathic principles on patient.

B2. After this visit, I make more research on the topic to improve my knowledge.

B3. I had to recognise that osteopathy alone cannot cure this condition.

C. SAFETY AND QUALITY IN PRACTICE ☑

Sub section number short reflection:

C1,C2. I couldn't perform a complete physical examination about patient's posture because he couldn't stand for more than two minutes. So, the tutor and I decided to perform a treatment to reduce the symptomatology and then to make a physical evaluation of the posture.

C8. I completed my patient's record promptly and the tutor checked it.

C9. Being overweight, this patient has difficult during some movements and I helped him to avoid any type of accident.

D. PROFESSIONALISM ☑

Sub section number short reflection:

D1,D2. The tutor and I decided to send the patient to the orthopedist and I prepared a report to give to the orthopedist.

D4,D5. The fact that the patient is Egyptian, didn't prejudice my patient's care.

D6. Personal informations about the patient are always keep reserved in respect of patient's privacy.

D7,D14. I honestly said the patient that I could just improve his symptoms but not totally resolve it.

D11,D12,D13. All necessary steps were taken to promote public health basing on health and safety legislation.

D14. I acted with integrity, honesty and sincerity because a lack of integrity in my practice could negatively affect patient care. I have not provided any misleading advertising or information about myself and my practice.

Any Additional evidence ☑

Reflective Journal 12

Long Reflection 4

Page number:

FRONT SHEET

ICOM EDUCATIONAL

Cinisello Balsamo, 30/11/17

STUDENTE FEDERICA TERZI Anno accademico 4FT

SUPERVISORE BRAMANTE N. MEDICO

Dati Paziente

COGNOME [redacted] NOME [redacted]

VIA [redacted] CAP [redacted] CITTA' [redacted]

RECAPITI: TEL [redacted] CELL [redacted] EMAIL [redacted]

REFERENTE AMICO

ETA' 55 (1962) SESSO F (M) OCCUPAZIONE COMMERCIANTE

Anamnesi Patologica Prossima

(1) Dolori polpacci e piedi: bilaterali, migranti riferiti alle gambe (sia anteriormente che posteriormente) e ai piedi non localizzabili in una zona specifica e costante. Dolori presenti da un anno ad esordio graduale. Riferiti come bruciore senza alterazioni cutanee. Insorgono quando cammina per circa 10 minuti, poi si deve fermare e sedere per 2/3 minuti affinché passi il dolore, dopodiché si ripete. Dall'insorgenza ad oggi non è cambiato le sintomo. Sporadicamente compare, durante la notte, si alza dal letto e cammina poco, migliora, ma poco.

Clinical log book 17

Date: January 2018

Observed ☑

Treated ☐

Patient front sheet included? ☑

Number: 17	Sex: male	Age: 24	Area treated: right ankle

Presentation

The patient is a young and normal weight man. He comes to the ICOM clinic for a right ankle pain referred in the area of the peroneal malleolus. On palpation the pain moves towards the heel. It is perceived in the inversion, eversion and during the maintained positions. It also senses a feeling of blockage and rigidity of the ankle, especially in the morning. The pain arose following a trauma occurred two years ago falling from motorbike. After the incident he had swelling without edema. He brought the crutches for three months. He suffered several sprains of ankle playing football over the years.

Hypothesis

1. Fractures of the peroneal malleolus
2. Lesion of peroneo-calcaneal and peroneo-astragalic ligaments
3. Dysfunction of subtalar joint
4. Contracture of peroneal muscles
5. Lesion of peroneal muscles' tendons

Red flags ☒

Examinations to support hypothesis

1. The patient can not currently have a fracture of the peroneal malleolus because two years have passed and a fracture would have already been repaired. Furthermore the Tinel test performed on the peroneal malleolus is negative.
2. The fact that after two years the patient still has pain may indicate a ligaments lesion. If the ligaments were totally broken, the patient would have felt pain in the initial phase and not subsequently. In addition his ankle would be unstable and after the trauma he had no signs of edema. He also has pain in the movements in which these ligaments are stretched and during palpation.
3. This hypothesis is validated by the fact that the patient feels stiffness and a sensation of joint blockage during walking. Following the trauma there could have been a joint impact between the talus and the calcaneus. The test for articular mobility of the subtalar joint was positive because there was no range of movement.
4. During the palpation the peroneal muscles were contracted because after the trauma they went into antalgic contraction. It is also for this reason that the patient reports ankle stiffness.
5. A lesion of the tendons of the peroneal muscles is excluded because there was no violet/blue edema after the trauma, which is tendon injury index.

Diagnosis

Chronic contracture of the peroneal muscles following antalgic contracture established two years earlier, with subtalar joint dysfunction. Possible lesion of the peroneo-astragalic and peroneo-calcaneal ligaments to be verified by ultrasound.

Treatment and patient advice

The treatment begins with general articulatory techniques on the ankle with subsequent specific articulatory techniques to the subtalar joint. An inhibition of the peroneal muscles is then performed, and finally an articulatory technique on the fibula together with a traction of the subtalar joint.

Reflective content: how does this patient fit into OPS grid?

Tick if the patient will be useful for

A. COMMUNICATION AND PATIENT PARTNERSHIP ☑

Sub section number short reflection:

A1. During this observation I saw that the operator was particularly quiet, sure of himself and clear in communication with the patient. In addition, the patient was young and was about our age so he felt at ease even though we were many students to see the visit.

A4. Every patient must give him or her consent and signs the informed consent before examination and treatment. In this way, the patient is always informs about who will perform the treatment and how the treatment will be performed.

B. KNOWLEDGE, SKILLS AND PERFORMANCE ☑

Sub section number short reflection:

B1, B2. The teacher showed us an excellent physical examination performed on the ankle. I have therefore learned to apply all the specific tests on the ankle and to make differential diagnosis between the various tissues.

C. SAFETY AND QUALITY IN PRACTICE ☑

Sub section number short reflection:

C2. I learned to formulate a specific treatment plan on the ankle in the event of trauma without major injuries such as fracture or ligament rupture.

C4. Although the boy was a contemporary, both the tutor and the operator were always respectful and considerate.

D. PROFESSIONALISM ☑

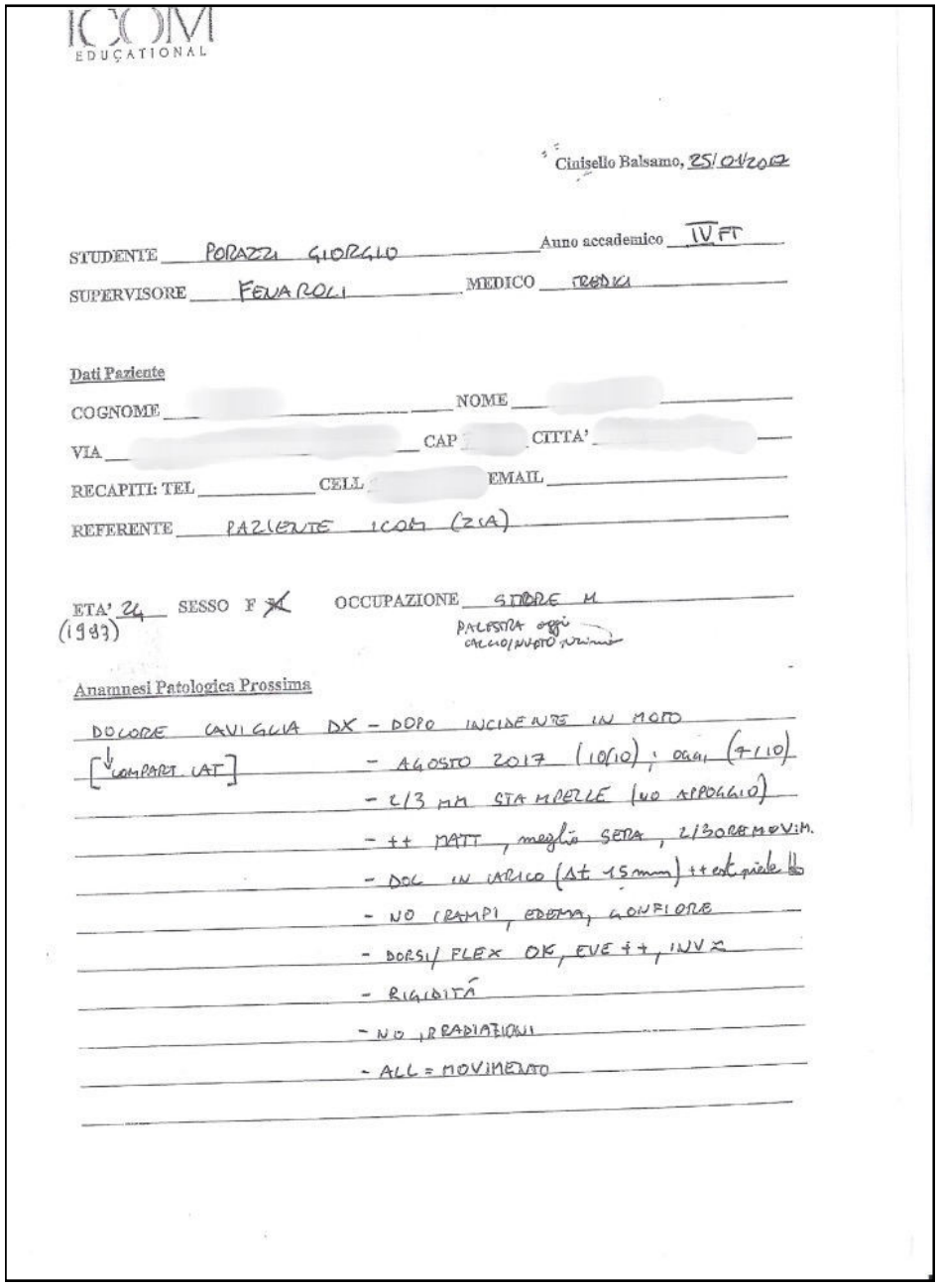
Sub section number short reflection:

D6. Personal informations about the patient are always keep reserved in respect of patient’s privacy.

D11, D12, D13. All necessary steps were taken to promote public health basing on health and safety legislation.

Any Additional evidence ☑ Reflective Journal 13 Page number:

FRONT SHEET



ICOM EDUCATIONAL

Cinisello Balsamo, 25/01/2022

STUDENTE PORAZZI GIORGIO Anno accademico IV FT

SUPERVISORE FENAROLI MEDICO TRENTA

Dati Paziente

COGNOME [redacted] NOME [redacted]

VIA [redacted] CAP [redacted] CITTA' [redacted]

RECAPITI: TEL [redacted] CELL [redacted] EMAIL [redacted]

REFERENTE PAZIENTE ICOM (ZIA)

ETA' 24 (1993) SESSO F ~~M~~ OCCUPAZIONE STUDENTE M
PALESTRA oggi CALCIO/NUOTO prima

Anamnesi Patologica Prossima

DOLORE CAVIGLIA DX - DOPO INCIDENTE IN MOTO
[↓ COMPART LAT]
- AGOSTO 2017 (10/10); OGGI (4/10)
- 2/3 MM STAMPELLE (NO APPOGGIO)
- ++ NOTTI, meglio SERA, 2/3 ORE MOV.
- DOL IN IMPACCO (Δt 15 mm) ++ ext. pieds
- NO CRAMPI, EDEMA, GONFIORE
- DORSI/FLEX OK, EVE ++, INV ≈
- RIGIDITÁ
- NO IRRADIAZIONI
- ALL = MOVIMENTO

Clinical log book 18

Date: February 2018

Observed ☑

Treated ☐

Patient front sheet included? ☑

Number: 18	Sex: female	Age: 46	Area treated: not trated

Presentation

The patient is a 46-year-old woman, normal-weight, employed and volleyball player. She comes to the ICOM clinic complaining about a shoulder pain present for about 3 months. This pain is widespread, there is no a precise point where it hurts and has arisen gradually without apparent causes. The pain is exacerbated when she has to wash her hair, fasten the bra behind her back and when at night she sleeps on the left side. Stiffness in making movements is also associated.

Hypothesis

1. Subacromial impingement

2. Rotator cuff syndrome

3. Adhesive capsulitis

4. Bursitis of the shoulder

Red flags ☒

Examinations to support hypothesis

1-2. To validate this hypothesis the hawkins, neer, drop and lift-off tests were made. Both were positive but not for subacromial pain or for pain on a precise muscle of the rotator cuff, but for general widespread pain caused by the rigidity of the movements. So they were considered negative.

3. This was the most accredited hypothesis since the first deficient movements were the rotations and abduction, typical of the frozen shoulder. Furthermore, absolute index of this pathology was pain and rigidity also in passive mobilization. The deep palpation of the joint capsule recreated pain in all parts, which means that the inflammation was extended to the entire joint capsule.

4. Palpation of the deltoid and bicipital bursa was negative. Also there were no signs of redness or heat cutaneous or edema. So this hypothesis was excluded.

Diagnosis

It was not possible to make a definitive diagnosis because, before starting osteopathic treatments, the doctor requested an ultrasound of the left shoulder to confirm the hypothesis of frozen shoulder.

Treatment and patient advice

The tutor, the doctor and the student have agreed to wait for the ultrasound report in order to establish a correct treatment plan.

Reflective content: how does this patient fit into OPS grid?

Tick if the patient will be useful for

A. COMMUNICATION AND PATIENT PARTNERSHIP ☑

Sub section number short reflection:

A3. Because the source of pain was unclear, the student tried to best explain to the patient what the frozen shoulder was in order to reassure her.

A4. Every patient must give him or her consent and signs the informed consent before examination and treatment. In this way, the patient is always informs about who will perform the treatment and how the treatment will be performed.

A5, A6. Because an ultrasound was necessary before the osteopathic treatment, the student, the tutor and the doctor recommended tothe patient perform the ultrasound as soon as possible in order to solve the problem quickly.

B. KNOWLEDGE, SKILLS AND PERFORMANCE ☑

Sub section number short reflection:

B1, B2. The student was particularly good at conducting an osteopathic patient evaluation to arrive at a correct hypothesis. She was also able to provide the tutor with references and scientific studies regarding the frozen shoulder.

B4. I personally deepened the topic of frozen shoulder as I did not feel sufficiently prepared about it.

C. SAFETY AND QUALITY IN PRACTICE ☑

Sub section number short reflection:

C1, C2. The student performed an excellent evaluation of the patient through specific tests that led her to the hypothesis of frozen shoulder. Furthermore, she was able to recognize that it would be better not to treat the patient in the first session, but it would have been better have an ultrasound first.

D. PROFESSIONALISM ☑

Sub section number short reflection:

D1. The patient was referred by a sonographer to perform an ultrasound scan in order to find the right diagnosis and establish the best treatment for her health.

D6. Personal informations about the patient are always keep reserved in respect of patient’s privacy.

D11, D12, D13. All necessary steps were taken to promote public health basing on health and safety legislation.

Any Additional evidence ☑

Long Reflection 3

Page number:

FRONT SHEET

ICOM EDUCATIONAL

Cinisello Balsamo, 19/02/18

STUDENTE Carbone Anno accademico 4°FT

SUPERVISORE Guirotti MEDICO Sala

Dati Paziente

COGNOME [redacted] NOME [redacted]

VIA [redacted] CAP [redacted] CITTA' [redacted]

RECAPITI: TEL CELL [redacted] EMAIL

REFERENTE Collega

ETA' 46 SESSO ~~F~~ M OCCUPAZIONE Assistente sociale (Pavullo)

Anamnesi Patologica Prossima

Da 9 mesi limitazione spalla sx. Il dolore non si presenta a riposo ma solo durante i movimenti ± rotazione interna

Primo episodio prima di Natale → rimasto di sottofondo poi peggiorato.

Fitte di dolore, poi passano.

Ha sempre dormito sul fianco sx, ad oggi non riesce più, si sveglia.

No perdita di forza.

No formicolio, no parestesia.

Antidolorifici → meglio il dolore, no la funzione

Clinical log book 19

Date: March 2018

Observed ☐

Treated ☑

Patient front sheet included? ☑

Number: 19	Sex: female	Age: 20	Area treated: not treated

Presentation

The patient is a young girl of 20 years, a normal-weight student, a former gymnast. She comes to the ICOM clinic complaining a pain in the lumbar area. This pain is perceived as a bilateral band costantly and as a central twinge after a workout. Aggravating factors are the extension, the positions maintained, the standing position maintained for a long time and the prone position. The only alleviating factor is flexion. She does not present scoliosis or irradiation to the buttocks or lower limbs.

Hypothesis

1. Contracture of the deep paravertebral muscles

2. Vertebral instability

Red flags ☑

What and why? Vertebral instability is a red flag because it could cause a stenosis of the spinal canal with consequent serious neurological symptoms. It could be caused by spondylolysis or spondylolisthesis.

Examinations to support hypothesis

1-2. Being a very young girl who has practiced for years artistic gymnastics and started it as a child, it is very possible that there is a general ligamentous laxity. The symptoms she describes are attributable to a contracture of the paravertebral lumbar muscles because the pain is bilateral band. However, this contracture is established on a possible vertebral instability. In fact the aggravating factors are the extension, the positions maintained during the gym exercises and the prone position. Moreover, the Passive Lumbar Extension Test and the Prone Instability Test are positive.

Diagnosis

Contracture of the lumbar paravertebral muscles on a possible vertebral instability

Treatment and patient advice

Because vertebral instability is considered a red flag, the patient was not treated on a first visit. She was sent to perform an X-ray of the lumbo-sacral tract in lateral projection.

Reflective content: how does this patient fit into OPS grid?

Tick if the patient will be useful for

A. COMMUNICATION AND PATIENT PARTNERSHIP ☑

Sub section number short reflection:

A1. During the interview with this patient, I was able to use my well-developed communication skills during other visits previously performed with other patients.

A3. Being a girl at the first academic year, during the visit I tried to make her participate as much as possible and to give her the information in the most appropriate and simple way in order to make her understand what the tutor and the doctor were talking about.

A4. Every patient must give him or her consent and signs the informed consent before examination and treatment. In this way, the patient is always informs about who will perform the treatment and how the treatment will be performed.

B. KNOWLEDGE, SKILLS AND PERFORMANCE ☑

Sub section number short reflection:

B1, B2. Thanks to the knowledge obtained during the studies, I managed to identify a very important red flag applying the osteopathic principles during the medical history.

C. SAFETY AND QUALITY IN PRACTICE ☑

Sub section number short reflection:

C1. I was able to carry out a proper osteopathic assessment of the patient sufficiently accurate that led me to hypothesise an important red flag and the tutor was in agreement with me.

C4, C6. During the visit there were many students watching and I immediately asked the patient if it was a problem or she felt uncomfortable and she said that it wasn't a problem.

C8. I completed my patient's record promptly and the tutor checked it.

D. PROFESSIONALISM ☑

Sub section number short reflection:

D1. To make sure the patient did not have vertebral instability, she was sent to make an X-ray of the lumbosacral tract.

D7. Both the tutor and I were honest with the patient explaining her possible clinical situation

D6. Personal informations about the patient are always keep reserved in respect of patient's privacy.

D11, D12, D13. All necessary steps were taken to promote public health basing on health and safety legislation.

D14. I acted with integrity, honesty and sincerity because a lack of integrity in my practice could negatively affect patient care. I have not provided any misleading advertising or information about myself and my practice.

Any Additional evidence ☒

FRON SHEET

ICOM EDUCATIONAL

Cinisello Balsamo, 8/3/2018

STUDENTE FEDERICA TERZI Anno accademico 4FT

SUPERVISORE C. FENAROLI MEDICO PAOLA TRENICI

Dati Paziente

COGNOME [redacted] NOME [redacted]

VIA [redacted] CAP [redacted] CITTA' [redacted]

RECAPITI: TEL _____ CELL _____ EMAIL _____

REFERENTE STUDENTESSA ICOM 4FT

ETA' 20 (1998) SESSO (F) M OCCUPAZIONE STUDENTESSA

SPORT: EX-GINNASTA PER 6 ANNI (SMESSO 2 ANNI FA)

Anamnesi Patologica Prossima

(1) Lombalgia: presente da 6 anni, iniziata in concomitanza col menarca. Zona lombare bassa bilaterale percepito come una fitta durante l'estensione oppure percepito costante nei giorni dopo allenamento e dopo un esercizio di ginnastica.
Fattori aggravanti: dormire prona, portare un peso sulla schiena, sollevare un peso anteriore tornando dalla flessione, posizioni mantenute durante alcuni esercizi o quando sta tanto in piedi.
Fattori allevianti: flessione del busto.

Clinical log book 20

Date: March 2018

Observed ☐

Treated ☑

Patient front sheet included? ☑

Number: 20	Sex: female	Age: 21	Area treated: right scapolomeral girdle

Presentation

The patient is a young 21-year-old girl, normal-weight, student, horse rider. She comes to ICOM clinch for a posterior thoracic pain in the right periscapular zone. This pain arose 2 years ago during horseback riding; she held the reins in her hand and the horse tugged her forward. Since then she feels a burning in the periscapular zone and a stab during the deep and forced inhalation, the coughing and the sneezing. Aggravating factors are the movements of abduction and extension of the right upper limb, bringing the bag on the right shoulder and sleeping on the right side. There are no alleviating factors.

Hypothesis

1. Strain of the periscapular musculature
2. Impingement of the zygapophyseal facets
3. Impingement of the costovertebral joint
4. Disease of the respiratory system

Red flags ☒

Examinations to support hypothesis

1. This hypothesis is validated by the fact that the pain has had a traumatic onset in which the scapular girdle has been tractioned forward bringing the periscapular musculature in sudden lengthening. In fact, the pain is perceived as a constant burning that increases with the movements of the upper limb as the periscapular musculature is also activated. Moreover, at the palpation the periscapular muscles are contracted and painful.
2. This hypothesis is excluded because the pain is not exacerbated by any movement of the spine and no articular limitation of zygapophyseal joints is perceptible to palpation.
3. This hypothesis is confirmed by the fact that the pain worsens with costal movements during inspiration, coughing and sneezing. Furthermore, the pain worsens by sleeping on the right side and carrying the bag on the right shoulder as the costovertebral joints are more closed. Moreover, on palpation the costovertebral joints of the K3-K4-K5 ribs are very stiffness.
4. This hypothesis has been ruled out because the onset of the symptom has been traumatic, moreover two years have passed and the patient has no abnormal symptoms linked to respiratory function.

Diagnosis

Impingement of K3-K4-K5 costovertebral joints with periscapular muscles strain

Treatment and patient advice

Myofascial techniques on periscapular dorsal musculature, GOT techniques on the scapolomeral girdle, articulatory techniques on the K3-K4-K5 ribs, traction techniques on scapolomeral girdle and a HVLA technique on the costovertebral joints were performed.

Reflective content: how does this patient fit into OPS grid?

Tick if the patient will be useful for

A. COMMUNICATION AND PATIENT PARTNERSHIP ☑

Sub section number short reflection:

A1. During the interview with this patient, I was able to use my well-developed communication skills during other visits previously performed with other patients.

A3. Being a girl at the first academic year, during the visit I tried to make her participate as much as possible and to give her the information in the most appropriate and simple way in order to make her understand what the tutor and the doctor were talking about.

A4. Every patient must give him or her consent and signs the informed consent before examination and treatment. In this way, the patient is always informs about who will perform the treatment and how the treatment will be performed.

B. KNOWLEDGE, SKILLS AND PERFORMANCE ☑

Sub section number short reflection:

B1. Thanks to the acquired experience I managed to apply the osteopathic principles and concepts during the patient's visit.

C. SAFETY AND QUALITY IN PRACTICE ☑

Sub section number short reflection:

C1, C2. I was able to conduct a sufficiently accurate osteopathic evaluation of the patient to to make a correct diagnosis and formulate an adequate osteopathic treatment plan.

C8. I completed my patient’s record promptly and the tutor checked it.

D. PROFESSIONALISM ☑

Sub section number short reflection:

D6. Personal informations about the patient are always keep reserved in respect of patient’s privacy.

D11, D12, D13. All necessary steps were taken to promote public health basing on health and safety legislation.

D14. I acted with integrity, honesty and sincerity because a lack of integrity in my practice could negatively affect patient care. I have not provided any misleading advertising or information about myself and my practice.

Any Additional evidence ☒

FRONT SHEET

ICOM EDUCATIONAL

Cinisello Balsamo, 12/3/2018

STUDENTE FEDERICA TERZI (FCCA DALLA PRIA) Anno accademico 4 FT

SUPERVISORE R. FILA MEDICO SALA

Dati Paziente

COGNOME [redacted] NOME [redacted]

VIA [redacted] CAP [redacted] CITTA' [redacted]

RECAPITI: TEL [redacted] CELL [redacted] EMAIL [redacted]

REFERENTE STUDENTESSA ICOM

ETA' 21 (1996) SESSO X M OCCUPAZIONE STUDENTESSA

SPORT: EQUITAZIONE DA 7 ANNI, TUTTI I GIORNI

Anamnesi Patologica Prossima

3) Dolore cervicale/spalla bilaterale: alternato e diverso tra dx e sx;

- dx zona periscapolare percepito come una morsa, associato a rigidità in rotaz estx, e flex arto superiore dx. Peggiora portando la borsa sulla spalla dx o dormendo sul fianco dx e quando, tenendo le briglie a equitazione l'incorto due anni fa durante equitazion quando il cavallo e' ha strattonato in avanti. Oggi è sempre associato ai movimenti, ma è aumentata la frequenza.
- sx zona trapezio riferito come un bruciore sottocutaneo non associato ai movimenti. Non presenta né fattori

Clinical log book 21

A1, A2, A3, A4, B3, B4, C1, C2, C3, C6, C7, D3, D8, D12, D13, D14

Date: September 2018

Observed ☐

Treated ☑

Patient front sheet included? ☒

Number: 21	Sex: male	Age: 35	Area treated: left arm and left shoulder

Presentation

The patient is a 35-year-old man, normal-weight, worker who plays football once a week. He comes to ICOM clinch for cervical pain related to left shoulder. This pain arose 4 years ago without a specific cause. He feels a weight in the left part of the neck and on the left shoulder. He also feels a pin during extension movement in C4-C5 level. Aggravating factors are extension movement and cold. Alleviating factors are stretching, digital pressure and heat. He broke his left elbow 5 years ago.

Hypothesis

1. C4-C5 herniation
2. C5 radiculopathy
3. Impingement of the zygapophyseal joints
4. Vertebral instability
5. Muscle chronic contracture (trapezius and sopraspinatus)

Red flags ☒

Examinations to support hypothesis

1. This hypothesis is excluded because the pain is not a central pin. Moreover the patient does not feel pain during movement after maintained position and he did not have any acute cervical pain in past. Spring test was negative.
2. This hypothesis is excluded because the pain is neither an electric shock nor a tingling pain. Moreover neurological exam is negative as Compression/Distraction Test.
3. This hypothesis is take into consideration because the cervical pain is exacerbated by extension movement and an articular limitation of zygapophyseal joints is perceptible to palpation.
4. This hypothesis is excluded because the pain is not bilateral and it is not irradiated as a neurological pain to the arms. Moreover the patient did not have any trauma on cervical spine. Finally, Spring Test is negative.
5. This hypothesis is validated by the fact that the pain is a weight that improve with heat, stretching and digital pressure.

Diagnosis Impingement of the zygapophyseal joints at C4-C5 spine level associated to a muscle chronic contracture of trapezius and sopraspinatus due to the internal rotation of the humerus which has been created after left elbow fracture.
Treatment and patient advice Myofascial techniques on pectoralis major, biceps and coracobrachialis muscles to reduce the anterior closure of the left shoulder. Articular technique on elbow to improve extension movement. HVLA technique on C4-C5 to reduce the impingement of zygapophyseal joints.
Reflective content: how does this patient fit into OPS grid? A1 You must have well-developed interpersonal communication skills and the ability to adapt communication strategies to suit the specific needs of a patient. The history collection and this patient's visit were particularly effective. In fact, communication with this patient was rather simple as my questions were very precise and his answers were relevant and specific. During the visit I was very satisfied with achieving a good level of communication. Relational and communication skills are learned through clinical experience; moreover it is not easy to succeed in establishing a good osteopath-patient relationship right away. I asked non-generic questions, in fact the patient answered me specifically. Thus, I was able to take a medical history in an accurate and less chaotic way. The osteopath, as a health worker, must be able to adapt his/her communication strategies to the patient. As we are people and not robot, however, there will certainly be random major and minor compatibility with some patients. Therefore, I think that with this patient there was a greater affinity than with others. So, despite being satisfied with the level of communication achieved in this visit, I will continue to try to improve my communication strategies both with other patients and with the same patient over time. I think that a specific course on osteopath-patient communication will also be very useful.
Any Additional evidence ☒

Clinical log book 22

A1, A2, A3, A4, A5, A6, B1, B2, B3, C4, C5, C7, D1, D2, D4, D11, D12, D13

Date: November 2018

Observed ☑

Treated ☐

Patient front sheet included? ☒

Number: 22	Sex: male	Age: 57	Area treated: right lower limb

Presentation

The patient is a 57-year-old man, normal-weight, employee who runs four time per week. He comes to ICOM clinic for an acute right knee pain: the pain is under the patella anteriorly and it ascends along the thigh posteriorly. This pain arose 1 week ago because he fell down from stairs. The patient describe the anterior pain as deep; the posterior one is a sharp pain perceived during knee flexion. Aggravating factors are flexion movement (also during going up and down the stairs) and standing position on the right lower limb. Alleviating factor is just rest. During physical examination the knee was slightly swollen and a little red, but he did not have any bruise after the fall.

Hypothesis

1. Patello-femoral condropathy
2. Meniscal injury
3. Impingement of the tendon of the semimembranosus muscle
4. Patellar fracture
5. Capsular sprain

Red flags ☒

Examinations to support hypothesis

1. This hypothesis is validated by the fact that the onset is a trauma specific on the knee and there is a little swelling and redness without a big edema. Moreover the pain was aggravated by flexion and extension movement. Finally, Raspa Test and Hyperpressure Test are positive.
2. This hypothesis is excluded because the orthopedic tests are negative. Moreover he brought a medical report of the ultrasonography and there was any meniscal lesion.
3. This hypothesis is validated by because the posterior pain was evoked with specific palpation on the semimembranosus tendon. Moreover it was aggravated by the squat movement.
4. This hypothesis is excluded because the Tinel Test on the patella was negative. Moreover he brought a medical report of the X-Ray and there was any fracture.
5. This hypothesis is taken into consideration because the onset was a trauma and there was a local swollen.

Diagnosis The anterior pain is due to a patello-femoral condropathy. The posterior pain is caused by the impingement of the semimembranosus muscle tendon and a probable capsular sprain.
Treatment and patient advice Articulatory techniques on right knee to improve extension movement associated to direct inhibition and myofascial techniques on semimembranosus muscle. Treatment of pelvic and thoracic diaphragm to improve venous drainage in order to reduce the inflammatory process on the knee.
Reflective content: how does this patient fit into OPS grid? C9 Act quickly to help patients and keep them from harm. During the observation of this treatment, the patient was very suffering. Especially in some small movements, the patient felt very strong pangs in the knee and his lower limb sagged. At a certain point, while the student and the tutor performed the postural examination with the patient standing, he was about to fall due to a very strong knee pain. The student was able to support the patient with the help of the tutor. They then immediately made the patient lie down and continued the postural examination with the patient on the bed. This experience made me realize how is important the readiness a therapist must have every time. Personally, I don't know if I would be able to support a patient much heavier than myself. I therefore think that I will equip myself with help and precautions to avoid any unpleasant situation that could put the patient's safety at risk.
Any Additional evidence ☒

Clinical log book 23

A1, A2, A3, A4, A5, A6, B1, B2, B3, C4, C5, C7, D1, D2, D4, D11, D12, D13

Date: November 2018

Observed ☐

Treated ☑

Patient front sheet included? ☒

Number: 23	Sex: female	Age: 67	Area treated: abdomen

Presentation

The patient is a 67-year-old woman, slightly overweight, retired and former dressmaker. She presented to ICOM clinic with pain in the great trochanter's area in the right lower limb. This pain arose 1 years ago without a specific cause. She described the pain as a non specific weight. Aggravating factors are walking for more than one hour and cross her legs. Alleviating factor is rest. During physical examination the great trochanter's area did not have any inflammation sign. She suffered from gastroesophageal reflux and hiatal hernia for many years. She underwent surgery for hiatal hernia in November 2017.

Hypothesis

1. Arthrosic degenerative process of the hip
2. Hip impingement
3. Psoas impingement
4. Bursitis
5. Aseptic necrosis of the femoral head
6. Chronic contracture of gluteus muscles

Red flags ☒

Examinations to support hypothesis
1. This hypothesis is validated by the fact that the onset is not specific and the pain arose gradually. Although pain is not typically inguinal, hip arthritis can report pain to the great trochanter. Moreover, the patient is unable to cross her legs. Furthermore, the Faber Test is positive for reducing the range of joint movement. However, movement is an aggravating factor, but in arthrosis movement is a relieving factor. 2. This hypothesis is excluded because the orthopedic tests were negative. 3. This hypothesis is excluded because the orthopedic tests were negative. 4. This hypothesis is excluded because there was any inflammation sign on the great trochanter and the pain was not reproducible with local palpation on the great trochanteric bursa. 5. This hypothesis is excluded because Anvil Test was negative and there were not pain on the palpation of the femur. 6. This hypothesis is validated by the fact that the onset is not specific and the pain arose gradually. Moreover the gluteus muscles were aching at palpation, especially near the great trochanter. Furthermore, movement is an aggravating factor and rest is an alleviating one.
Diagnosis
The pain in the great trochanter area is due to an initial arthrosic degenerative process of the hip which is concomitant with a chronic contracture of the right gluteal musculature.
Treatment and patient advice
Patient's pain in the right hip was due to a functional overload given by an altered postural scheme both on the lateral and anterior-posterior plane. As for the lateral scheme the patient had a first pelvic degree with descending priority located in the D6-D9 tract. Instead, on the anterior-posterior plane, she had an abdominal priority. I practiced visceral techniques on great and small curvature of the stomach, on cardia, on diaphragm with the aim of reducing reflux an to improved her posture.

Reflective content: how does this patient fit into OPS grid?

B2 You must have sufficient knowledge and skills to support your work as an osteopath.

Postural examination of this patient showed that the priority on her scheme was the visceral problem related to gastroesophageal reflux and hiatal hernia surgery. She was my first patient with a gastroesophageal reflux so important to alter her whole posture. For this reason I decided to focus almost all osteopathic treatment on improving reflux.

To do this I decided to deepen my knowledge a lot about manual reflux treatment. Since during the research and the literature review I found data regarding a considerable spreading of reflux among the population, I decided to write my final research project on this topic. Thus, I gained more knowledge about it that I put into practice during my treatments.

Furthermore, this patient was the first person who needed visceral osteopathic techniques. Although the literature concerning visceral techniques is meager, the effects they produced on this patient were truly excellent.

Although I will not write a research project for every topic, whenever I will find difficulties or will recognize my lacks, I will not hesitate to consult the scientific literature. I believe it is a duty to our patients to always have excellent knowledge because we perform manual techniques on their bodies. I also think that continuous training and personal growth through professional refresher courses are fundamental.

Any Additional evidence ☑

What and why: The postural evaluation of this patient was very particular because a visceral problem affected her musculoskeletal pain although they were two parts of the body that were distant from each other.

Page number:

Clinical log book 24

A1, A2, A3, A4, B2, B3, B4, C1, C2, C3, C8, C9, D4, D5, D7, D11, D12

Date: November 2018

Observed ☑

Treated ☐

Patient front sheet included? ☒

Number: 24	Sex: female	Age: 69	Area treated: left external rotation hip muscles

Presentation

The patient is a 69-year-old woman, normal-weight, retired and former shop assistant. She presented to ICOM clinic with pain in left low back. This pain arose 2 years ago, gradually and without a specific cause. She described the pain as dull in the lumbar but sharp and shouting in the leg. Indeed she also had a radiation laterally to the left thigh, calf and foot. Aggravating factors are rotations of lumbar spine, especially in bed. Alleviating factor are massage, heat and walking. The pain was stronger at night. The patient reported that she sweats a lot during night and it induced her some problems in sleeping. Medical history: appendectomy, whiplash. The patient suffers from polymyalgia.

Hypothesis

1. Discopathy
2. Radiculopathy
3. Piriform syndrome
4. Vasculitis
5. Chronic contracture of spinal erectors

Red flags ☒

Examinations to support hypothesis

1. This hypothesis is excluded because the onset was not traumatic and the patient did not report any acute lumbar pain in the past. Moreover the pain was not central but was asymmetric on the left side. Spring Test, Compression Test and Distraction Test were all negative.
2. This hypothesis is excluded because Compression Test, Distraction Test, Slump Test and Lasègue's Test were all negative. However, during neurological exam, lower extremities reflexes L5-S1 was weak on the left limb. Lower extremities sensibilities and strength were good.
3. This hypothesis is validated by the fact that the onset is not specific and the pain arose gradually. Two of the alleviating factors are massage and heat, indexes of muscle contracture. There are neurological signs of a suffering of the root of L5-S1, but all the tests on the lumbar spine were negative; therefore a suffering of the sciatic nerve is validated. Moreover muscular palpation of left gluteus muscles and piriformi was tenderness.
4. This hypothesis is excluded because the onset was 2 years ago and there were not any vascular sign.
5. This hypothesis is validated by the fact that the onset is not specific and the pain arose gradually. The pain was dull in the lumbar and alleviating factors were massage, heat and walking. Moreover the muscular palpation of spinal erectors was aching.

Diagnosis

Left low back pain is attributed to a degenerative spine that have caused a deep contracture of spinal erector. In addition, the patient suffers from piriform syndrome. The whole symptomatology may have been aggravated by the polymyalgia.

Treatment and patient advice

Left gluteus muscle and pyriform inhibition with patient in right side lying. Treatment of left Valleix points.

Reflective content: how does this patient fit into OPS grid?

C3 Care for your patients and do your best to understand their condition and improve their health.

During the patient's anamnesis I found difficulties to understand the source of the symptoms. Initially, I thought that the pain in her leg and her lower back were one consequence of the other. However, when all the tests on the lumbar were negative, I started thinking about a peripheral neurological syndrome.

Nevertheless, I did not understand why the pain in the leg was perceived by the patient with such a high intensity. Moreover, during the treatments the intensity of the techniques performed was modulated because the patient was always very sore. All this depended on the pathology of which the patient suffered for years, namely polymyalgia rheumatica.

Polymyalgia rheumatica (PMR) is a relatively common chronic inflammatory condition of unknown etiology that affects elderly individuals. It is characterized by proximal myalgia of the hip and shoulder girdles and it causes a greater perception of general pain.

For this reason, during osteopathic treatment on a patient like this, it is necessary to have a greater sensitivity and engage in understanding the patient without underestimating her perception of pain.

Any Additional evidence ☒

Clinical log book 25

A1, A2, A3, A4, A5, B1, B2, B3, B4, C1, C2, C3, C6, C7, D1, D3, D4, D5, D11, D12, D13

Date: December 2018

Observed ☐

Treated ☑

Patient front sheet included? ☒

Number: 25	Sex: female	Age: 23	Area treated: trapezius muscle and CD spine

Presentation

The patient is a 23-year-old woman, normal-weight, student and swimmer. She presented to ICOM clinic with right sub occipital pain. This pain arose 6 months ago, gradually and without a specific cause. She described the pain as a stiffness especially in the morning, that continues as an ache during the day. It reaches the upper fibers of the trapezius on the right side. Aggravating factors are holding position and cold, but there is no particular movement that aggravates the symptomatology. Alleviating factor are massage, heat and clicking the high cervical spine by herself. Whiplash in the past.

Hypothesis

1. Chronic contracture of sub occipital muscles
2. Sub occipital trigger point
3. Chronic contracture of trapezius muscle
4. Trapezius trigger point
5. Discopathy
6. High cervical spine instability

Red flags ☒

Examinations to support hypothesis
1. This hypothesis is validated by the fact that the onset is not specific and the pain arose gradually. Two of the alleviating factors are massage and heat and the third is continuous clicking the high cervical spine, index of muscular tension. The aggravating factors are holding positions and cold. Moreover the sub occipital muscles are painful at palpation. 2. This hypothesis is excluded because there was a general tenderness during sub occipital palpation and there wasn't any specific tender point which induced the same irradiation of the patient's pain. 3 - 4. This hypothesis are validated by the fact that the onset is not specific and the pain arose gradually. Two of the alleviating factors are massage and heat, indexes of muscle contracture. Moreover muscular palpation of trapezius was aching and there was a specific tender point which induced the same irradiation of the patient's pain, index of a trigger point. 5. This hypothesis is excluded because Compression Test, Distraction Test and Spring Test were all negative. However, one aggravating factor is holding position typical of discopathy. 6. This hypothesis is validated by the fact that the onset is not specific and the pain arose gradually. During both active and passive movements of cervical spine there was hyper mobility. The Instability Test was positive and the patient had a whiplash in the past.
Diagnosis
The pain is due to a cervical instability that created a contracture of suboccipital muscles in order to maintain the stability. Moreover, trapezius trigger point was felt during palpation, that played an important role in aggravating the pain in the upper cervical.
Treatment and patient advice
Trapezius trigger point inhibition, neuromuscular technique and HVLA technique on cervico-dorsal tract of the spine. Be careful to not touch high cervical and not perform neuromuscular technique on suboccipital and deep cervical muscles.

Reflective content: how does this patient fit into OPS grid?

A3 Give patients the information they need in a way that they can understand.

The final diagnosis of this girl was a high cervical instability with hypermobility of the spine. This condition is extremely dangerous if it is not taken into consideration by manual operators. In fact, the patient was used to click her neck by herself, not knowing that it would make the situation worse.

During the treatment she asked me if I could practice a high cervical HVLA so as to give her relief. However, I tried to make her understand that in her case it would not be a safe technique, in fact she could have made her symptom worse. I explained her that the neck click provides momentary relief, but in the long term it aggravates her hypermobility. For this reason she had a strong contracture because suboccipital muscles tried to maintain the high cervical stable.

Although she was not fully satisfied with the treatment I had performed because it had not given her the same benefit as the HVLA technique, she was confident in the treatment plan I had set out to her. Besides that, I advised her not to click her neck by herself anymore.

In the end, I was able to perform a treatment according to osteopathic principles and based on my knowledge despite not being what the patient wanted.

Any Additional evidence ☒

Clinical log book 26

A1, A2, A3, A4, B1, B2, B3, B4, C1, C2, C3, C6, C7, D1, D2, D3, D4, D11, D12, D13

Date: January 2019

Observed ☐

Treated ☑

Patient front sheet included? ☒

Number: 27	Sex: male	Age: 52	Area treated: not treated

Presentation

The patient is a 52-year-old man, slight overweight, road hauler. He presented to ICOM clinic with pain in the left shoulder: anterior part of the glenohumeral joint and deltoid region. This pain arose 3 months ago, traumatically in a specific moment and it was the first time that he felt this type of pain in his life. He described the pain as sharp and stubbing. He also had a radiation from deltoid region to forearm and middle finger which appears every time he feels pain in the shoulder. However, the radiation is described as a pain rather than pins and needles or tingling. Aggravating factors are every kind of movement of the shoulder: the most painful are external rotation and abduction. Alleviating factor is rest. He referred a loss of strength due to pain. There were no changes in temperature or colour, no chest pain or short of breath (excluded cardio vascular system). Medical history: ulcerative colitis associated with rheumatic disease (he did not remember exactly the name of the pathology). In his family there is a history of rheumatic disease (his mother suffered from anchyloses spondylitis). He referred to drink alcohol daily.

Hypothesis

1. Frozen shoulder
2. Supraspinatus muscle tendinopathy
3. Subacromial impingement
4. Radiculopathy of C7

Red flags ☑

Examinations to support hypothesis

1. This hypothesis is validated by the fact that the pain has an acute onset, indicating an acute inflammation of the shoulder. Any movement of the shoulder causes pain, above all external rotation and abduction, which are the first movements that are affected by this pathology. The only relieving factor is rest. Furthermore, on physical examination the internal rotation is limited both actively and passively. On the other hand, external rotation is impossible due to pain and stiffness. In abduction there are only 40° of movement and in the flexion there are about 50° of movement.

2 - 3. These hypothesis are taken into account, however they can be hidden by the frozen shoulder or be included in it.

4. This hypothesis is excluded because the pain is not related to the movements of the neck. Furthermore all orthopedic tests on the cervical spine are negative and the neurological examination is also negative.

Diagnosis

Frozen shoulder.

Treatment and patient advice

This patient was not treated but was referred to an orthopedist. He was also advised to perform instrumental shoulder examinations.

Reflective content: how does this patient fit into OPS grid?

D1 You must consider the contributions of other healthcare professionals to ensure best patient care.

Since the final diagnosis of this patient was a frozen shoulder, I decided not to treat the patient and send him to an orthopedist. This decision was made because the frozen shoulder is considered a redflag as it is a highly inflammatory disease. As such, the first medical treatment must be prescribed and viewed by an orthopedist.

I am very happy to have made this decision and realized that I could not intervene in an acute situation like the frozen shoulder. This does not preclude osteopathic treatments in the future, in fact the patient was told to return after starting anti-inflammatory therapy with the orthopedist. Future treatments will be aimed at gradually restoring joint movement of the shoulder.

Moreover, in the future I will aim to create stable collaborations with other professionals in the medical-health field in order to be able to collaborate with them. All this to achieve the best possible well-being of my patients.

Any Additional evidence ☒

Clinical log book 27

A1, A2, A3, A4, B1, B2, C1, C2, C4, C6, D1, D2, D7, D9, D11, D12, D13

Date: February 2019

Observed ☐

Treated ☑

Patient front sheet included? ☒

Number: 27	Sex: female	Age: 22	Area treated: diaphragm and abdomen

Presentation

The patient is a 22-year-old woman, normal-weight, acting student. She presented to ICOM clinic with headache. This headache arose 5 years ago without a specific cause. The pain occurred once a week and When it arrives, it has a gradual and not sudden onset. She described the pain as pulsating. The pain is bilateral and localized at the temples and near the eye sockets. She does not have prodromal signs as phosphenes or sparkles, but she has nausea. Aggravating factors are heat and phonophobia. Alleviating factors are rest and NSAIDs. Medical history: sinusitis during childhood. She also complains of heartburn and heaviness in her stomach almost every day and frequently takes antacids. From the intestinal point of view she suffers slightly from constipation for some years.

Hypothesis

1. Migraine
2. Tension muscle headache (temporal muscles)
3. Metabolic headache
4. Trigeminal neuralgia (ophthalmic branch)

Red flags ☒

Examinations to support hypothesis

1. This hypothesis is excluded because the pain is always bilateral.
2. This hypothesis is excluded because the headache is pulsating and it and lasts many hours. Moreover heat is an aggravating factors and not an alleviating one, and the patient does not feel benefit from massage of temporal muscles. However the pain is bilateral and improved with NSAIDs.
3. This hypothesis is validated by the fact that the pain is bilateral. Furthermore the location is at temples and eye sockets, typical of a metabolic headache. The type of pain is pulsating and she has nausea during headache. Moreover the headache has started along with the problems of constipation.
4. This hypothesis is excluded because the onset is not sudden and the pain is not evoked by skin touch or chewing. Moreover the type of pain does not have neurological characteristics.

Diagnosis Metabolic headache aggravated and related to intestinal constipation problems.
Treatment and patient advice Inhibition of all the diaphragms of the body: pelvic diaphragm, thoracic diaphragm, upper thoracic girdle, buccal floor and tentorium. Intestinal mobilization and visceral techniques on the mesentery root. Cranial sinus drainage.
Reflective content: how does this patient fit into OPS grid? C1 You must be able to conduct an osteopathic patient evaluation sufficient to make a working diagnosis and formulate a treatment plan. During the patient's medical history, I could not identify the type of headache that afflicted her. Before investigating the physiological history, I was struggling to make a differential diagnosis regarding the headache. When I asked the patient if she suffered from gastrointestinal problems, instead, I managed to make a correct diagnosis of metabolic headache. Based on this, I formulated an appropriate osteopathic treatment that would act on general fluid dynamics. I also gave the patient some advice on modifying her lifestyle in order to improve her condition. I was happy because I was able to think out a good treatment plan based on osteopathic principles. However, next time I will try to integrate the physiological history with the patient's pain immediately.
Any Additional evidence ☒

Clinical log book 28

A1, A2, A3, A4, A5, A6, B1, B2, C1, C2, C3, C6, D1, D2, D5, D7, D8, D11, D12, D13

Date: March 2019

Observed ☐

Treated ☑

Patient front sheet included? ☒

Number: 28	Sex: male	Age: 35	Area treated: right calf

Presentation

The patient is a 35-year-old man, normal-weight, workman, cyclist, motorbike pilot who goes to the gym 3 times a week. He presented to ICOM clinic with pain in the right knee in the back region. This pain arose some days before, without a specific cause. The first time he felt that pain was when he got out of bed one morning and he extended his knee. The day before he had performed a strong cycling workout. He described the pain as a pin in the popliteal fossa and as a pulling rope along the calf. Aggravating factor is only extension of the knee.

Hypothesis

1. Meniscal injury
2. Capsular sprain
3. Impingement of the tendon of the gastrocnemius
4. Trigger point of gastrocnemius or soleus
5. Contracture of gastrocnemius or soleus

Red flags ☒

Examinations to support hypothesis

1. This hypothesis is excluded because the orthopedic tests are negative.
2. This hypothesis is excluded because there wasn't any distortion trauma and the capsular wasn't painful during palpation. Moreover, there wasn't any inflammation sign or edema.
3. This hypothesis is excluded because the pain wasn't evoked by palpation specific on the tendon in the popliteal fossa.

4 - 5. This hypothesis is validated by the fact that the only aggravating factor was extension of the knee and that there were no signs of trauma or inflammation. Moreover the pain was evokes through the palpation directly on the muscle. To the touch the calf muscles were extremely stiff and aching. There was a particular point in the medial head of the gastrocnemius which was more dense and evoked the pain in the back region of the knee.

Diagnosis Contracture of right calf muscles and trigger point go medial head of gastrocnemius.
Treatment and patient advice Direct inhibition of right calf muscles, especially on the medial head of gastrocnemius, and articulatory technique on the knee for extension movement.
Reflective content: how does this patient fit into OPS grid? D5 You must comply with equality and anti-discrimination laws. This patient was not of Italian nationality, but he came from South America. Despite this, I didn't feel any difference in visiting it and treating it exactly as if it were my compatriot. During the visit the patient was always very kind and respectful towards me, and I was the same way with him. Throughout history there have been numerous acts of violence against people of other ethnicities. Despite this, unfortunately nowadays there are still intrinsic discriminative principles in a large part of the population. I am a person who fights a lot against these prejudices, even outside the work of osteopath. For this reason, in front of people of different nationalities, I take a more cordial and kind attitude. However, I think it is a mistake that I will have to try to improve especially in the workplace, because it is as if I highlight a sort of difference anyway. But, this difference must not exist. However, I will continue morally to assert my anti-discriminatory principles in front of people with principles opposed to mine.
Any Additional evidence ☒

Clinical log book 29

A1, A2, A3, A4, A5, A6, B1, B2, B3, B4 C1, C2, C3, C4, C5, D1, D2, D3, D12, D13

Date: April 2019

Observed ☐

Treated ☑

Patient front sheet included? ☒

Number: 29	Sex: female	Age: 14	Area treated: not treated

Presentation

The patient is a 14 young girl, normal-weight, student and volleyball player. She presented to ICOM clinic with pain in left ankle. This pain arose 3 days before, in a traumatic way with an ankle sprain while she was playing volleyball. She described a general pain that compressed the whole ankle, and specifically she felt strong pangs in two specific points: one in the anterior portion of the talus and one in the back between the talus and the calcaneus. Aggravating factors are plantar flexion, dorsal flexion, foot inversion and walking. Alleviating factor is only rest. There was not color edema but the ankle was really swollen, hot and reddened. She couldn't place her foot on the ground to walk.

Hypothesis

1. Ankle fracture

2. Ankle ligament lesion

3. Ankle tendon lesion

4. Capsular sprain

Red flags ☑

Examinations to support hypothesis

1 - 2 - 3 - 4. All these hypotheses have been taken into consideration due to the recent traumatic onset of pain. Although there were no purple or green edema, signs of internal lesions, it was possible that there were lesions to the musculoskeletal structures of the ankle. Since the pain was really high (8/10) and the ankle was difficult to palpate, it was not even possible to perform diagnostic tests to make a correct differential diagnosis.

Diagnosis

Ankle sprain with possible internal lesion.

Treatment and patient advice

The patient was not treated and she was sent to the emergency room to perform an ankle X-ray and an ultrasound of the ankle's muscle-tendon structures.

Reflective content: how does this patient fit into OPS grid? D1 You must consider the contributions of other healthcare professionals to ensure best patient care. Since the beginning of this visit, I have had no doubts about not treating the patient and immediately sending her to the emergency room. I think that, as the patient was very young and a sportswoman, the best thing to do would have been to act as quickly as possible for her well-being. Perhaps the tutor would have been able to better evaluate the ankle and more accurately thanks more years of experience behind him. However, due to my current abilities and my sense of responsibility, I preferred to act in this way and the tutor appreciated my sincerity and timeliness. I also think I have acted in the best way thinking about the well-being of the young patient.
Any Additional evidence ☒

Clinical log book 30

A1, A2, A3, A4, A5, A6, B2, B4, C1, C3, C4, C5, D1, D2, D5, D9, D11, D12, D13

Date: June 2019

Observed ☐

Treated ☑

Patient front sheet included? ☒

Number: 30	Sex: male	Age: 48	Area treated: diaphragm and ribs cage

Presentation

The patient is a 48-year-old man, normal-weight, engineer. He presented to ICOM clinic just for postural control because he had idiopathic scoliosis. The patient had scoliosis from the childhood, but he never brought any orthopedic aids. Moreover, he could not define Cobb's angle because he had not performed any instrumental checks related to scoliosis for more than 30 years. On physical examination the scoliosis started from the T3-T4 spinal tract and ended in L4-L5. The first part made a convex right curve that changed into a left convex curve through the dorsal-lumbar tract of the spine. All the landmarks of the pelvis were aligned, and the clavicles have a very small misalignment. In his physiological history he did not report any respiratory or cardiac problems, but he suffered from heaviness in the stomach after large meals. The patient had practiced some exercises in the gym to maintain muscle tone and increase his aerobic endurance.

Hypothesis

1. Postural control for idiopathic scoliosis

Red flags ☒

Examinations to support hypothesis

1. Being an adult person, it is not possible to intervene on the scoliosis itself because the column is structured. However the remaining part of the musculoskeletal system can be helped to be as functional as possible.

Diagnosis

Idiopathic scoliosis.

Treatment and patient advice

The main objective was to prevent the onset of respiratory or cardiac problems and to improve gastric problems. I performed diaphragm inhibition and a general osteopathic treatment on ribs cage. Then I did an indirect technique on mediastinum and I gave to the patient some breathing exercises.

Reflective content: how does this patient fit into OPS grid?

C1 You must be able to conduct an osteopathic patient evaluation sufficient to make a working diagnosis and formulate a treatment plan.

This first visit was my final FCCA clinical examination, and it was a disaster. Immediately after the exam, I was happy with the visit I had done and I was satisfied with the anamnesis that I had conducted under examination. However, the professors and the doctor who evaluated me agreed to give me the lowest possible score. When I found out about the outcome, I felt really sick.

I wasn't able to explain myself why the exam had been so bad that it had been a risk of not passed the exam. I couldn't understand what was wrong. So I started thinking about any possibilities or mistakes I could had made during the visit. Since they were all questions and I was looking for answers, I requested the contacts of the professors who evaluated me at the exam and a personal interview with the director of the ICOM clinic. Despite this, or contact or appointment wasn't given to me.

Unfortunately I still remain with questions and doubts and no answer or certainty. However, this experience has aroused in me a profound self-critical analysis of my attitude with the patient and with the professors, and about my real skills and knowledge. Not having certain answers, this exam made me question everything.

I do not know if there will be a "next time" because I do not know if I will still hold an examination like this one. However, for the first time, I cannot say what I could do in the future because I have not yet succeeded in understanding what I did wrong in this visit.

Any Additional evidence ☑

What and why: Being a structured idiopathic scoliosis, active exercises are essential for the patient to integrate together with manual osteopathic treatment.

Page number:

Reflective Journals

REFLECTIVE JOURNAL 1: Clinical Logbook 1

I saw my first visit as observer on March 2016 and it has been a new experience. The patient was an interesting and complicate case. She came to ICOM Clinic complaining a pain in the right shoulder girdle. However, to me the most important thing has been the patient was affected by depressive bipolar syndrome and that she had started suffering from that psychosis state after a car crash. The patient took more than five drugs daily in contrast to her psychiatric disease. For this reason was a little weird.

I felt powerless in front of that situation. At the very beginning I thought about how brain is important and strong on who people are and on what people do. The most shocked thing was the patient had been a normal girl, but her life changed overnight. Life had changed also to her parents and her family. The patient had become aggressive with others (parents, doctors, friends, etc) and with herself. Indeed she had tried to suicide and had practiced self-harm.

The first negative aspect was the fact that I completely became involved in patient's history and my humanity totally came out. Then, I overlooked patient's pain for which she came to clinic. If I had been in the operator shoes, I wouldn't have been able to manage the situation in the right and professional way. The positive aspect was that her history got me thinking about significance of changes and about the fact that none knows what will happen tomorrow or in an hour.

Certainly, I became involved so much because it was my first experience as observer in clinic. Furthermore, I had never met a person with such important and shocking history. I didn't expect that people with such severe problems and illness would go to the osteopath. Moreover, people with psychiatric or psychologic disorders. Indeed, I had to change my mind also because the tutor proposed a global type of treatment to improve patient's general physiology and conditions relating to her depressive state.

To me, it has been a useful and significant experience both for osteopathic growth and for personal growth to face daily life outside of university or job. On the osteopathic point of view, it has been interesting seeing how manage a patient with psychological disorders.

This experience makes me realise how much important is the dialogue with the patient, especially in this evenience. So, I will looking for some books which talk about the relationship between the patient and the operator and about the patient's management.

(430)

REFLECTIVE JOURNAL 2: Clinical Logbook 3

I observed this first visit on May 2016. The patient was a woman very funny and smart. She came to ICOM Clinic because of low back pain due to lumbar muscles chronic contracture. She had been several acute episode in previous years. The first one had been in 1995 and she had had another acute event one year before the visit. The interesting thing was that there were a temporal relationship between these episodes and cesarean section and dental implant. Indeed, the patient had had the first acute pain after the second cesarean section. Furthermore, she had had the dental implant one year before the visit.

I felt fascinated and curious when the tutor explained these possible correlations and influences. I didn't watched how they could impact on patient's low back pain. On physical examination, the tutor showed that there were a great imbalance on the anterior-posterior axis. The tutor also demonstrated that imbalance of the abdomen was due to the double cesarean scar and that imbalance of the head was due to a class II malocclusion with tongue thrust. I thought about how much magnificent is the osteopathic science and I asked myself If I would ever be able to make such specific physical examination.

One positive aspect was that I learnt how much and how a cesarean scar and a mandibular dysfunction could influence people's posture. Another positive side was that I felt stimulated to study more and more to improve myself.

The observation of this first visit has been a useful experience because it's difficult find patients with correlation of many different body systems. Furthermore, one of my friend suffers from low back pain and she has cesarean scar.

All in all, I saw how making a good and complete physical examination. Moreover, having never seen the effect of a cesarean section on posture, I wasn't able to perform a good physical examination on my friend. So, this experience increased my background.

I certainly will study more and more to improve my ability on making physical examination and I'll try to study the posture of my friend with the cesarean section.

(360)

REFLECTIVE JOURNAL 3: Clinical Logbook 5

I observed this first visit on September 2016. The patient was a man with two different pains. The first on was in posterior part of the right shoulder due to a chronic muscular contracture. He had been practising ballroom dancing and he had had to support his lady with the right shoulder in abduction and extension position using the posterior muscles of shoulder. The other pain was a lost of sensitivity in the anterior part of thigh due to the compression of lateral femoral cutaneous nerve which caused the Meralgia Paresthetica. This was the first time I saw a patient with the Meralgia Paresthetica and I was really interesting in it. The tutor was a professor who I looked up because she had a specific and proper method to make the anamnesis. However, she overlooked the second problem of the patient.

I went to the tutor after the first visit and I asked her what osteopathy could have done in case of Meralgia Paresthetica and how the operator could have helped the patient. I made these questions because I was really curious and interested, but the tutor just answered me that osteopathy could have done nothing for the Meralgia Paresthetica. I felt bad because I expected a more complete and justified answer. Also because other professors had told me that osteopaths are able to improve this problem.

I think I did right to ask the tutor my question. Indeed I am at the university to learn and it's my right to make questions and to receive answers. In my opinion, the tutor didn't behave

in a fair manner towards me. Furthermore, ignoring patient's problem hadn't been a professional act.

I was disappointed by tutor's answer because she didn't fulfil my curiosity and because I had looked up her very much. On the other hand, the tutor might really had thought osteopaths couldn't help the patients with Meralgia Paresthetica, but she didn't explain me the reason.

However, I could have looked for the answer myself and I could made my question after some days in order to have a real comparison with the tutor. Surely, I won't feel bad any more If a tutor don't answer to my questions. Indeed, I would hear the opinion of others professors in that case.

On first, I will try to look for informations and answers by myself when I'll have a question or a doubt. Then, I will ask the tutor my questions and tell him or her what I found about it. In this way, there will be a comparison between my findings and tutor's knowledge. Moreover, I will hear the opinion of more than one tutor.

(450)

REFLECTIVE JOURNAL 4: Clinical Logbook 8

On April 2017 a patient came into ICOM Clinic presented lower back pain (a central pain like sudden blade and a bilateral one more general and continuous) with stiffness in the morning. The general pain got better with warmth, but the central one not. It was my first patient because that day was my first day as operator in clinic and a student older than me, help me to make a good evaluation and planning the right treatment. During the visit the tutor came into the room and he also helped me and made me some questions about the patient but at first, I wasn't able to answer because I had forgotten to ask to the patient some information.

I felt really excited because it was my first day as operator and she would became my first patient, but at the same time I was afraid because it has been the first time that I treated a person. I also felt a bit nervous when the tutor came into to ask me about the patient's pain and posture, but, fortunately, there was the other student that had helped me before on the

evaluation of the patient. However, I was unhappy because I has not been able to manage the patient by myself in the right way.

It has been certainly a great day for me because I began to relate to patients and I was happy to have an older student that helped me. I was unhappy because I didn't completely understand by myself what type of pain the patient had and because in front of the tutors I was insecure.

At I first I was a bit afraid because I had to explain to the patient that from that day I would be her operator and that it was my first time. Some patients don't want another operator and maybe don't return to the following appointments, but fortunately it hasn't been my case. Then I was so full of enthusiasm and nervousness, that I forgot to make the right specific question to the patient about her pain and, when the tutor asked me about patient's pain, I didn't know what to answer. Subsequently the other student helped me and I was able to understand the origin of patient's problem.

It was a really important experience for my personal growth even thought I made a very important mistake. However that was absolutely my first time and I also think that is fairly normal. But it was a great lesson for me because from that time I always ask on first what type is patient's pain.

From that time I get less nervous both with patient and tutor, and before starting every treatment I write on the patient's record the word "symptomatology-pain" so when I see my patient, my first question is specific on her pain and I immediately write the answer.

(490)

REFLECTIVE JOURNAL 5: Clinical Logbook 9

The patient was assigned to me by a fifth-year student who was about to graduate. She was a very young girl, still a minor, asymptomatic. She had come to the ICOM clinic for postural control and maintenance treatment because she had been diagnosed with scoliosis. Unfortunately, due to an unpleasant misunderstanding, the patient no longer came to the clinic to be treated because she had felt uncomfortable in being observed by some male students.

Being one of my first visits, I was still not able to manage very well the situations both with the patient and with other students. I felt mortified when I realised that the girl was feeling uncomfortable due to the presence of a particular boy. In fact, he had entered in my room to observe the treatment in order to admire the beauty of the girl and not to observe her in a neutral way from a osteopathic point of view. In addition to being mortified, I was also ashamed of the presence of this boy and I felt very annoyed.

I believe there are no positive aspects to be drawn from this visit. The young patient has never returned to be treated because of this boy and because of my fault that I was not able to reproach him and ask him to leave the room. Perhaps the only positive thing is that having experienced an embarrassing and unpleasant situation like this, I will never let it happen again. It was really a pity to lose this patient because it was really interesting to see how osteopathic treatment had a conservative effect on her scoliosis.

It is unacceptable that a student, who do clinical training on real patients, takes advantage of it and behave in this way. When a boy decides to take up this profession, he must not create embarrassment with female patients or make them feel uncomfortable. Even more if the patient is a very young girl and moreover a minor. It is an index behaviour of immaturity and lack of professionalism. On the other hand, I have not been able to adequately defend my patient. But once I had finished the visit I talked to this guy and told him what I thought about his behaviour.

Some professors have warned us female students telling us that surely in our careers there will be men who will try to expose their own emotional interest towards us. On the other hand, the male students have been absolutely told not to make female patients uncomfortable.

If in the future a similar situation should ever happen again, I would immediately ask if the patient feels uncomfortable in front of other students and I would immediately tell the person concerned to leave the room without hesitation.

(470)

REFLECTIVE JOURNAL 6: Clinical Logbook 10

This patient was assigned to me by a girl of the last year who graduated. The patient si asymptomatic since several months, so it is interesting to continue to perform a physical examination to find and maintain the corrections on his altered posture. However, the patient has no cure for his personal hygiene. He's come to the clinic with a very unpleasant odor, dirty underwear and with a general lack of cleanliness of the whole body.

I was very surprised because I think it is inconceivable to have so little care of themselves, especially if you have to go to a clinic where sis is treated so touched by other people. I felt particularly uncomfortable because I would have like to tell the patient to wash up, making him also notice that his behaviour is rude and it is disrespectful to the people who have to take care of him. Moreover, i always pay close attention to both my personal hygiene and the cleanliness of everything around me. So it was really a rather unpleasant situation.

I have difficulties to find a positive aspect in this experience as there seem to be only negative aspects. The worst thing is that I had to deal with a person who has a concept of cleanliness totally opposite to mine. And that moreover has no qualms to be treated by me in those very low hygienic conditions. The only positive aspect is that this experience has happened to me in the clinic where I am surrounded by tutors and people older than me to whom I can ask for help and advice.

I believe that anyone should have adequate personal hygiene especially when deciding to go to any health clinic. I don't think it is my duty as a student to tell to a patient that he should wash and change at least intimate clothing before being treated.

For my personal hygiene and my protection from infectious diseases, I tried to deepen the cutaneous rush by asking the patient what kind of dermatitis he had. So, I looked for information about it to make sure that this type of dermatitis was not transmissible with touch. I did not find particularly alarming information for the operator, but rather for the patient in case he was not cured.

Surely from this experience I realised that not all people have the same conception of personal hygiene and that I do not have to assume that a person is washed before coming to the clinic to be treated. After dismissing the patient, I talked to tutors who told me that

nothing could be done. So I will ask the secretariat if it is possible to put signs in which the importance of personal hygiene is explained with the moral obligation to show up at the clinic at least with adequate personal cleaning. In addition, I will perform the next treatments with latex gloves and I will tell the patient that I have an allergy at the hands so I am obliged to cover them, in order to not offend him.

(520)

REFLECTIVE JOURNAL 7: Clinical Logbook 11

The patient was one of the first patients assigned to me by a fifth year girl. This patient has been attending the ICOM clinic for many years. Her peculiarity was that at each appointment she reported a pain that was always different from the previous one. Furthermore, every pain was always described with much suffering although in the end they were caused by very slight problems. For this reason I was not very able to manage the patient and to follow a postural scheme on which to work in a constructive way and constantly.

Not being able to manage the patient I felt a bit ineffectual and I feared that my insecurity was perceived by the patient and interpreted incorrectly. However, being one of my first visits, I asked to the tutor who was following me, to help me every time. Unfortunately, after a few treatments I had to change my day of clinic and the patient could not move the appointments to another day due to work commitments. When I learned that I would not follow that patient any more, I felt both relieved and discouraged.

Surely managing a patient like this is not a simple thing. I think it takes a bit 'of experience to understand how to relate with this type of patients. When I spoke with the tutor, he told me that often patients who change their symptoms each time, suffer from a kind of depression. The downside was definitely that I could not follow the patient anymore, but I understood it after a while.

Having a patient of this kind in front of me certainly made me understand that not all people come to the clinic for a specific symptom. Indeed, there are some patients who need to spend an hour for themselves to feel better. For this reason they come to clinic to be treated complaining every time a different and very mild symptom although they

describe it as if it were a very serious thing. Reflecting on it, it was a pity not to be able to follow this patient because I would have surely learned how to manage these situations better.

We never did a real lesson about managing these patients. Instead we have always focused on specific symptoms. But a professor told us about one of his patients who had gone to the osteopath and started talking about all his unfortunate life, except for his pain. The professor explained to us that in that time the man was in a very high state of stress, so the osteopath could not have done much. That patient needed to talk with someone about his problems. My patient seemed very similar to the professor's patient

I have learned that people can see the figure of the osteopath as a person to whom tell own problems. Not just physical pains, but also those of a sentimental and psychological nature. For this reason, once the university is finished, I will further deepen the psychological aspect of people in order to better manage patients of this type.

(515)

REFLECTIVE JOURNAL 8: Clinical Logbook 12

This patient was assigned to me after being visited by another student. Unfortunately the student before me, had not performed a good physical examination, so when the patient passed in my hands, I had to redo the full objective examination. The patient's pain (described in detail in the clinical logbook) was caused by an imbalance of the postural pattern on the anteroposterior plane with priority on the level of the double scar of two caesarean sections. In re-examining the physical examination I tried to be as specific as possible, but I did not understand very well that the cause of the postural imbalance was the abdominal scar. The tutor who was following me advised me to evaluate the posture of the lumbar spine in correlation with the caesarean scar. So I managed to find the priority of the scheme.

It was my first case in which an abdominal scar affected all the patient's symptoms. However, I was quite happy with the physical exam I had developed without the help of the tutor; getting then whole picture of the situation with the tutor's teachings, I felt definitely more satisfied.

The fact that I have had a case like this in ICOM clinic is very positive because I have been able to test my skills and express my doubts to a professor. After treating the scar, the patient's improvement was astounding, both in terms of the imbalance in the anterior-posterior pattern and in terms of her symptomatology. Probably if there had not been the tutor to direct me to the priority, I would have treated the dysfunctions I had found on the antero-posterior plane, but maybe they would not have solved the patient's symptoms immediately.

In this situation the greatest challenge was to find the right correlation between the posterior structural part of the spine and the anterior abdominal part and understand which of the two influences the other. In everyday life, many people may have an abdominal scar following cesarean delivery, hysterectomy, interventions to the gastrointestinal tract, renal transplants, etc. So, it was good to come across this case because it made me realize how much a scar can influence a postural pattern and how important it is to treat it.

At the time of the first visit I followed the tutor's advice on how to treat the scar and I performed some abdominal tissue release techniques in correlation with the lumbar spine. Subsequently, I deepened the subject by doing some research on cesarean scar treatments (Wasserman et al., 2016; Chamorro Comesaña et al., 2017; Wang et al., 2009), as well as having purchased a book on the treatment of all types of scar. (Bordoni and Zanier, 2015) So on subsequent visits, I also tried to apply what I had learned from my research after exposing them to the tutor.

In treating this patient, I could certainly have tried to correlate the scar with the anterior-posterior postural pattern by myself. However, being supported by tutors is useful to learn new things. I have therefore learned to make a good physical examination introducing the alterations given by abdominal scars and to treat them correlating them with the skeletal structure.

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(670)

REFLECTIVE JOURNAL 9: Clinical Logbook 13

I participated in this visit as an observer. The patient was a woman particularly intimidated by the presence of us students and felt a little uncomfortable. It was a very difficult case because she presented two big problems. The first was of a physical nature; during her birth she had undergone a partial medullary injury of the motor neurones on the right side of the body. She then presented an incomplete hemiparesis on the whole right half of the body. The second problem was of a psychological nature; her child had died aged 10 years a few years earlier. For this reason she had gone into depression and was still under pharmacological care. With all these problems, the student, who was carrying out the visit, panicked.

Putting me in the shoes of the student, I think that I too would have been in serious trouble. I would not have known how to behave in front of an important physical problem like her, or in front of her depression for the death of the son. In addition, my biggest question was "How should an osteopath behave in front of a medullary lesion with half-body hemiparesis?”

The patient was particularly uncomfortable talking for the presence of us students and was not pleased to expose her problems in front of everyone. Despite this, she was extremely gentle and made us stay throughout the medical history. Subsequently instead all of us students went out not to make her feel uncomfortable further. Unfortunately we could not attend the physical examination and the analysis of the severity of the hemiparesis, but she appreciated this gesture very much and felt more at ease.

This observation was particularly instructive because I had never seen a patient with partial hemiparesis in ICOM clinic. Obviously it was very sad to hear the story of the death of her son. But this experience has made me more sensitive and respectful to a suffering person. It also reminded me that the real problems are not those I face in everyday life, but the serious problems are very different from mine. From the clinical-medical point of view, however, this experience has been useful to deepen the topics of the hemiparesis and the complications that may occur during childbirth.

At the time of the visit the tutor said that for the hemiparesis we could not have done anything. At the same time, the student could not have worsened the situation, so the patient could be treated but without strong and direct techniques. Regarding childbirth complications, they have been addressed in pediatric and cranio-sacral courses during the study of osteopathic treatment on children.

If I ever have a patient like this woman, I would certainly be very sensitive and respectful about her preferences and her eventual discomforts. I would probably feel a little uncomfortable in front of a patient with a history behind this type, but I would try to stay calm. It was also useful as a case because it showed me one of the limits of osteopathy against a neurological problem such as hemiparesis.

(520)

REFLECTIVE JOURNAL 10: Clinical Logbook 14

This patient was the first to whom I made a complete first visit. He was a young man who was playing football and was complaining of a heel inflammation. I tried to carry out the anamnesis in a precise and accurate way and I have certainly been embarrassed and a little insecure because it was my first complete visit. The problem came when the patient complained to me and the tutor for the time we were taking to visit him, saying that no one had warned him that it would last so long and that if they had warned him, he would not come.

I felt bad about hearing these things, especially because I tried to do everything better. Even the tutor was a bit surprised and tried to take the situation into his own hands.

Despite this, he also tried to reassure me by telling me that in theory all patients know that they come to a clinic where they are treated by students.

When the patient expressed his complaints, I began to wonder what I had done wrong during the interview and the medical history. Then, I reflected on my way to ask the questions, I also asked for an opinion to my companions who were observing. The worst thing is that the patient has not returned to the next appointments, which means that he was very annoyed.

I do not think that patient behaved well towards me. I think it was neither my fault nor his fault if he had not been warned by secretery before making the appointment. However, I could certainly have been quicker and more intuitive in asking the questions, so as to reduce the time of the visit.

From this experience I learned to be quicker in asking questions and understanding if I have a person available or who has little time. Honestly, it was mortifying to know that the patient no longer came. However, in the subsequent visits I will immediately say the time it will take to carry out the visit to the best and to understand if the patient is available or has other commitments.

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REFLECTIVE JOURNAL 11: Clinical Logbook 15

The patient came to the ICOM clinic for unilateral pain at the inguinal level due to chronic contraction of the right psoas muscle. Since osteopathy doesn't treat just the symptom, but seeks the cause that triggered the symptoms, the aim of this visit was to understand why the right psoas muscle had contracted despite the absence of a trauma. I then performed a complete physical examination to investigate the lateral postural scheme as the symptom was unilateral (index of a postural imbalance on the lateral plane). As always, I was followed by a tutor.

By studying the pelvic degree of the pelvis I was able to understand that the problem was caused by a descent and not by a problem coming from the lower limbs. However, I could not find the priority at in the spine that influenced the lateral scheme, but the tutor helped

me. Seeing the teacher perform the exclusion tests in a very specific way by examining one vertebra at a time, I felt a bit ‘mortified.

The positive aspect of this visit was to see how the teacher performed the tests in a specific and meticulous way. The priority was found in a lateral curve with left convexity in T4. Although I had successfully completed part of the physical exam, I still did not feel satisfied with myself because I had not been able to find the priority by myself. However, the professor was very kind as she reassured me telling me that the skill is improved with experience and practice.

I believe that the main challenge of this visit was to investigate the lateral postural pattern well, since the patient's symptom was triggered only by an altered posture and not by a trauma or a specific event. I think sometimes I'm too hard on myself and I think I want everything immediately, but to improve in any discipline it takes dedication, time and patience.

During the course of Osteopathic Principles held by the Director Mandara, I have studied well the total physical examination of the patient. As far as the investigation of the lateral scheme is concerned, we have focused a lot on:

- pelvic degrees of the pelvis in order to understand if the imbalance is caused by a descending problem or by a problem coming from the lower limbs;
- the side curves of the column;
- the relationship between the convexities found in the column with the lower limb ipsilateral to the convexity.

From this visit I learned how tests should be performed in a more specific way by investigating one vertebra at a time. Also I learned that I do not have to discouraged if I can not perform something in an excellent way, but rather I have to take it as a cue to improve myself more and more.

(470)

REFLECTIVE JOURNAL 12: Clinical Logbook 16

This patient came to the clinic complaining of a particular symptomatology of the lower limbs, better described in the clinical logbook. The singularity of this visit was that the patient was a foreigner, in particular he was Egyptian. It was the first time I had a foreign patient. I did the whole visit in the best way possible, trying to make myself understood by him and trying to understand him. Despite this, I must admit that as soon as I learned from the secretariat that the patient was a foreigner, I thought of some prejudices.

After initially having some prejudices, during the visit I felt really stupid. Knowing him also on subsequent visits, I must say that he was a lovely man, dedicated to family and work. At each appointment he arrived scented and wore his shirt every time (personal hygiene is not a factor to be taken for granted). Thinking back to the first visit, I really was stupid.

The fact of having a foreign patient is a very important and also a beautiful experience. It is not easy to communicate with a person who does not know your own language very well. It was therefore interesting to find a simple language and a way to communicate. Obviously the negative aspect of this experience has been my initial prejudice of which I am ashamed.

I believe that my initial prejudice was dictated by a daily habit in which we live. Today's society is considered to be very integrated, in which various nationalities intertwine without problems. The truth is that the differences between the various populations are underlined and highlighted every day by the news and the facts that happen every day around us. I do not consider myself a bad person at all. Socially speaking, we are all human on the same level and with the same rights. Personally, however, I like to meet people from other countries and other cultures. For this reason I was ashamed of myself for the things I initially thought.

I have therefore learned to communicate with a foreign patient in such a way as to make me understand and understand him in the best possible way. Furthermore, I absolutely promised myself that I would never again have any kind of prejudice about the patient regardless of his nationality.

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REFLECTIVE JOURNAL 13: Clinical Logbook 17

I participated in this visit as an observer. The patient was a young boy, 24-year-old with an ankle pain following a motorcycle accident two years earlier. The visit was conducted by both the student and the tutor. Pain in the ankle was singular because in the aftermath of the trauma he had not reported any diagnosed lesions and had not had any purplish edema. However the pain persisted.

During the visit I had made of my hypotheses concerning the ankle. And I was particularly pleased with myself when during the discussion of the case, the tutor explained her hypotheses which corresponded to mine. However, I wouldn't have been very able to make a correct differential diagnosis between the anatomical structures placed among the hypotheses. The tutor instead explained how to distinguish the structures in the ankle in such a way as to understand specifically which is the one that gives pain.

The fact that I have been thinking about the same things the tutor has thought of, is very positive. It means that I finally have a more analytical mind and when a patient exposes his or her pain, I can clearly see which structures could be the cause. However, the fact that I would not have been able to make a correct differential diagnosis among my hypotheses, it means that I still need to gain experience by observing other professors.

I think it is good to have deduced the same hypotheses of the tutor as the goal of these years of university is to be able to hold visits alone in front of a patient and in total safety for his or her health. The fact that I have to improve the ability to make differential diagnosis is an indication that I am still learning and that I need to deepen and study better some topics.

In this regard I have carried out research concerning the manipulative techniques on the ankle. In particular, an excellent improvement has been seen in terms of range of movement and proprioceptive stability in studies where a manipulative treatment was applied combined with stretching within an entire treatment protocol. (Davenport, Kulig and Fisher, 2010; Weerasekara et al., 2017) On the other hands, HVLA techniques on ankle joints used individually gave poor results in range of movement. (Fryer, Mudge and McLaughlin, 2002)

From this visit I learned to analyze in a better way the ankle structures in order to make a correct diagnosis and practice specific tests. Also from my research I have found that the treatment of the ankle should always be seen in the perspective of a treatment protocol and not of a single HVLA technique because there are many joints inside and different connective tissues, so it is good to treat them by combining stretching, mobilization and functional exercises.

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REFLECTIVE JOURNAL 14: Willard Seminar

In January 2018 I attended a seminar held by Professor Frank H. Willard on the neurovegetative system. This course was organised specifically for us students of the fourth academic year and was held at the ICOM headquarter in Cinisello Balsamo. In those days the lessons and the clinical internship were interrupted and even students from other headquarters ICOM came to attend the seminar. The lecture was held entirely in English as the professor is a professor of anatomy at the New England College of Osteopathic Medicine since 1989 and is an honorary member of the American Academy of Osteopathy.

I was particularly excited to follow his seminar as he is a great privilege for us students to meet him in our school without having to pay external courses. It was not the first time I attended one of his seminars because he held one even in the month of September 2017 about the gastrointestinal system. Being all very important topics, I also focused a lot to

follow the whole lesson. In addition, the professor was extremely good at making the lesson engaging using slides, images and videos.

I have been particularly good as I was able to follow the whole lesson despite being entirely in English. I also managed to take complete notes while listening to what Willard was explaining. Receiving such detailed explanations about the human body from an anatomist like him, it was certainly another positive aspect and a privilege. Unfortunately, when he tried to interact with the class, I would have answer a few questions, but I was ashamed to speak English in front of all those students.

As our university collaborates with international teachers and doctors, it also offers advantages and services that other schools do not offer. In addition, the Director Mandara proposes these obligatory seminars as it requires a high level of knowledge from his students.

Already during the third and fourth academic years we had studied the autonomic nervous system during the course of SNA and Osteopathic Medicine held by the teacher Liria Papa. However, this seminar was used to better understand some of the functionalities of our body that are based on the physiology of the autonomic nervous system. Also from the anatomical point of view, during the first academic year we attended the Anatomy classes and the teacher Giorgio Germano showed us some videos of anatomical dissections. In this seminar Willard showed us his anatomical dissections and explained them to us in a specific and detailed way. Fortunately, it does not impress me to see these things.

If it should happen again to attend a seminar held by professor Willard, I will work to put aside my shyness and I will try to answer him if he'll ask some questions. My other goal will be to get to the lesson having already reviewed the topics he will explain; in fact us students always know in advance what the title of the seminar is. In this way I will be able to better understand his reasoning and anatomical and pathological references.

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SEMINARIO

«Formazione avanzata in anatomia funzionale: il sistema neurovegetativo»

Prof. **Frank H. Willard**
New England College *of Osteopathic Medicine* - Maine

29 e 30 gennaio 2018

REFLECTIVE JOURNAL 15: English Exams B1+ and C1

In February 2018 I took the English exam for the C1 level at the British Institute school. It was not my first exam because in July 2017 I supported the one for the B1 + level. During the second, third and fourth school years I attended English courses organised by the British Institute in collaboration with the ICOM. Since for me English has always been an obstacle (for a fact that happened at the age of 12 in middle school), being able to pass this test was very satisfying.

The part where I felt the most agitated was always the oral part as I felt uncomfortable talking in front of an English teacher. Despite this, the speaking part has always been the one that went better than everyone. Obviously on the day of the exam I felt particularly nervous, but after finishing it I was always satisfied with myself.

To take part in the MSC course I had to reach the C1 level, so I was very worried about not being able to pass the exam. For this reason I had planned an efficient study plan in which every day I practiced in grammar, reading, listening and in the speaking with some friends or alone. In this way I was able to face both exams at best, despite the agitation.

In addition to having passed the exam of the C1 level, the other positive note was that in part I managed to overcome my personal obstacle. In fact, at the age of 12 my English teacher had made fun of me in front of the whole class because I did not understand the meaning of an acronym, and all my classmates had started to laugh at me. Thinking about it today, I still feel uncomfortable. However, at the British Institute I met a very good teacher who was able to stimulate the students and bring out the best in each one. For this reason, in part I managed to overcome this thing, although it may seem insignificant and trivial in the eyes of others.

Being an ambitious and programmer girl, I have a list of the things I want to do in my life. Among these there is a study experience abroad. For this reason one of my goals will be to participate in a master's degree in a foreign country and to do so I will always have to keep my English coached and improve it. In fact, I decided to start reading the Harry Potter books (which I adore) in the original language and once the university is over, I would like to have private conversation lessons in order to improve my pronunciation and fluency.

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REFLECTIVE JOURNAL 16: First Elective Visit

During the first Visit the English teachers started with the presentation of the elective's program. The class was divided in two groups and each group works with some teachers on the morning lesson and with the others on afternoon. The first day we practiced with the web site of Science Direct and begun to analyse some research and in the afternoon we studied biomechanics. The second day we saw how to make a reflection and its different parts and how it's structured an academic writing. The third day we practiced some biomechanical notions with rehabilitation exercises.

Before that lessons I had been excited to meet new teachers and to know more about the electives course. During the visit 1 I was a bit scared because my English isn't so good, especially in conversation, I become shy. For this reason I had been thought that I wasn't able to understand all the things.

I appreciated the numerous activities organized by different teachers, for example looking for some research on Science Direct, try to invent many rehabilitation exercises with some clinical case or playing with the all class to see if we understood the mainly concepts of the lesson. Another very interesting thing was the part about reflection because I think that not many people reflect and analyze their actions on work or study.
The difficult, but non bad, part was that sometimes I didn't understand the teachers and I felt despondent or maybe bored.

I first began the lessons with a lot of enthusiasm but when I didn't understand something I felt hopeless and during conversation I didn't try to have a dialogue because of my insecurity. In those situations I explained my feelings to my classmates and they encouraged me. Also the Italian tutors helped me.

It was a pleasure experience because for the first time I met a team composed by many English teacher and despite of my difficulties with language, I was able to understand most of the explanations and at the end of the third day I was more relaxed. After this first learning experience I increased my aims both in language and especially in study; I'm now curious to participate to the next visit and I want to start with my portfolio.

I will concentrate more when I won't understand something and in this case I will try to ask

questions; this will help me to pass my insecurities. I think that I will take more notes during the lesson in order to revise it at home.

(430)

REFLECTIVE JOURNAL 17: A.N.O.A. Course

In November 2017 I took part in an extra course organised by one of the ICOM teachers. This course was open to fourth and fifth year students and to those who had already graduated. The title was "The inguinal region: anatomical, clinical and diagnostic deepening". I decided to take part in this course because I am still a student and I obviously have shortcomings compared to people who already work as osteopaths, so I had the opportunity to learn more and learn new things. I also took the opportunity to meet new professionals and see how they work.

Being the first course I attended, I was particularly excited about the idea. On the other hand I was one of the younger so I felt a bit 'in awe. Surely I'm getting closer and closer to the professionals world of osteopaths and I can not be Peter Pan forever.

Surely attending this course was a more than positive choice as I learned a lot of new things. The collaboration between osteopaths and an orthopaedic surgeon was particularly instructive. For each pathology the osteopath and the orthopaedic treatments have been proposed, showing how the two figures can work together and support each other. Another very interesting section was held by another professor involved in the osteopathic management of professional sportsmen. Unfortunately this course was done in just three days very intense and every day the lesson lasted more than 8 hours. I think if it had been organised in more time, it would have been even more productive.

The topics that were treated from an anatomical, clinical and diagnostic point of view were:
- femoro-acetabular impingement with the distinction pincer-FAI and cam-FAI
- radiographic analysis of the pelvic girdle
- lesions of the cotyloid cercine
- iliopsoas syndrome
- painful syndrome of the great trochanter
- coxarthrosis

- pubalgia

The most important things I have learned are the manual practice of performing tests and of trimming anatomical structures at the groin level. It was also helpful to see how an osteopath relates to an orthopedist and how the osteopath's work can be parallel to that of the orthopedic. Finally, the clinical part was very useful as it showed us how to make a good differential diagnosis in the case of pain in the inguinal region.

(415)

REFLECTIVE JOURNAL 18: Challenger ATP Como

At the end of the third academic year, students were invited to participate in an ATP Challenger Tour in the city of Como as trainee. Me and another student have proposed ourselves and for ten days between the month of August and September 2017 we have been part of the medical staff of the ATP Challenger Tour organised at the Tennis Club of

Villa Olmo. For ten days, I traveled 80 km every day to participate in this fantastic experience.

Although I had lost my last week of summer holidays, I was thrilled to be part of a complete staff in an important Tennis tournament known as ATP Challenger. I was accompanied by a teacher and an assistant with more years of experience than me, so I felt reassured. However, having to deal with real professionals for the first time, I was a bit nervous because I doubted my skills both relational and practical.

Treating tennis players was really a big challenge for me because they have a tone and a muscle mass that is noticeably different from that of the patients I usually treat. Furthermore, they had quite high expectations and required specific treatments both before and after the game. It was not possible to make mistakes otherwise they would not play well and lose the match. It was therefore the first time that I felt a big responsibility on my shoulders. Despite this, the two tutors who were there taught me how to manage the athletes both from the communicative point of view and on the treatment plan, teaching me also new things.

Obviously it was not ten easy days because I worked all day from morning to night; moreover when I returned home, I did another job and I was very tired. However, I could not have missed an important opportunity like this. I think that every student has a lifetime in front of him, but that now is the moment when every opportunity must be seized on the fly in order to learn as many things as possible and have as much knowledge as possible in the world of osteopathy.

I know that the tournament is organised every year and I hope the two reference tutors still ask me to participate. It is also right that other students have the same opportunity that I have had. However, if I were to return to work as a trainee in that tournament, I would be more confident of myself even in front of the athletics and I would put into practice the things I learned during this fourth academic year and in the ICOM clinic.

(450)

REFLECTIVE JOURNAL 19: International Tennis Cantù Wheelchair

In April 2018 ICOM proposed to us fourth year students to participate as trainees in the First International Wheelchair Tennis tournament organised by the Tennis Club of Cantù. Although the effort would have been only for one day, I immediately decided to participate. Both because I like to participate in any experience, both because having already participated in the staff of Tennis Club of Como, I was extremely curious to compare the two experiences. Attending this event has been really a fortune to me.

I felt thrilled at the idea of observe wheelchair players and to be able to treat them. However, having never dealt with disabled people, I did not know how to managed them from a practical point of view. While we were watching the tournament at some point it started to rain a lot and we went under a gazebo. Obviously the athletes were all in wheelchairs and they couldn't be covered by rain all together because the place was small. For this reason I had them all put around a table and we started playing "Boy-Girl-Animal" but with categories concerning the medical-scientific field. In this way the athletes were able to organise themselves with the wheelchairs to be all under the gazebo, plus we had fun while we waited for the rain stopped.

It was therefore a great challenge to find a solution also from the organizational point of view. From the osteopathic point of view instead, the only difficulty I encountered was in moving the patient on the bed. In fact, although for them it is normal and they do anything with extreme ease, in some cases I felt embarrassed to ask for displacements or try to turn around. So, I tried to find solutions by modifying the techniques I knew.

Sometimes in the classroom we have dealt with the topic: how would you treat a patient with a physical disability? Obviously no one knew the exact answer and we students tried to guess. I decided to participate in this internship in order to find the answer to that question by myself.

The differences I found between this Cantù Wheelchair Tennis tournament and the Como ATP tournament can be summarised in two categories: behavioural and practical. I have already explained those practices above regarding the execution of the techniques or moving the patient on the bed. The behavioural ones instead refer to the needs of the athletes. In the Como tournament the athletes came to be treated having in mind a precise

idea of what they wanted and they had very high demands. In this tournament instead the athletes were more humble and more available.

Obviously, if the opportunity to participate in this tournament should happen again, I would not hesitate to accept the proposal. Until then I will better investigate the practical and manual management of patients with physical disabilities.

(490)

Long Reflections

LONG REFLECTION 1: Down Syndrome

During the clinical observational internship I happened to attend a visit of a man with Down's Syndrome. The man was 50 and was accompanied by his mother. In fact, it was the mother who told the patient's medical history.
The problem he referred was a pain in his right knee due to dislocation of the patella. This thing had happened for the first time some years before, and it had happened very often initially. In the last two years instead it happened rarely, but every time there was a very strong pain in the knee. At the time of the visit the patient did not report pain, but the mother said that in some movements there was a very acute pain in the front and side of the knee, without the displacement of the patella, but with swelling that lasted for a few days. This pain was very disabling as it prevents him from walking.
In addition, the mother, in telling us the patient's medical history, told us that he was an active man who practicing sport and work. Moreover since childhood it has always been followed by specialized centers for physiotherapy and to control growth during childhood, adolescence and adulthood.

When I saw that the patient on the visit was a man with Down's Syndrome, I felt very lucky; I do not know how many students are lucky enough to witness a case like this. Moreover, I had never thought about the occurrence in which a patient with Down's Syndrome would come to be treated by the osteopath. So this experience was actually a great opportunity to get to know another area of osteopathy. If I had been in the role of the operator I think I would have been a little nervous, at least in the initial phase because I have never had to deal with a patient like that and us students have never even treated the topic in class. The student operator was really good at managing the situation as he listened to both the mother and the man himself because in some moments he intervened by saying his opinion and his personal thought.

After attending this visit, having never studied the topic in depth, I decided to update my knowledge and look for the consequences that the Down's Syndrome, also called trisomy 21, can lead to a physical level. During the discussion of the case the tutor had already

told us that in these patients the most important thing to remember is the congenital ligament laxity. Above all it is considered very dangerous in the articulation between the atlas and the tooth of the epistropheus. In fact, 20% of people with Down's syndrome have orthopedic complications and the most important is the ligament instability of the high cervical spine. It is obviously very dangerous and to be kept under control since the tooth of the epistropheus could dislocate and go to compress the spinal cord due to the laxity of the transverse ligament of the epistropheus. According to some studies carried out on children and others on adults, the frequency of atloaxial instability varies from 14% to 25% diagnosed by RX. The worst thing is that only 2% of these subjects have symptoms, so it is very important to keep under control the evolution of instability especially to avoid risks during physical activity. (Mundakel, 2018; El-Khouri et al., 2014)

Patellofemoral instability with patella dislocation is another common orthopaedic problem in Down's Syndrome people. This condition is caused by a series of concomitant changes: muscular hypotonous, ligament instability, articular hyperlaxity, valgus knee, asymmetry of tibia or femur. Both surgical and conservative therapies have been considered for the treatment of patellofemoral instability. Unfortunately, several studies have been done on treatment in childhood, but the consequences that they then had in adulthood are not known. (Duque Orozco et al., 2016)

Among the alternative therapies to the surgical treatment that have been taken into consideration, can be found the chiropractic combined with additions of vitamin and certain types of hormones. However, as explained above, people with Down Syndrome have ligament instability and hyperlassity. So chiropractic treatment should be done with particular caution and in severe cases it should be discouraged. (Cohen, 1996)

Based on this, osteopathic treatment therefore can not try to improve these conditions, as they are genetically prescribed. They also represent very important contraindications to treatment to be taken into consideration. However, osteopathy may be useful in patients with Down Syndrome especially in the pediatric age.

It has been shown that much of the nerve tissue degeneration occurs after birth and is associated with hypoxemia. This condition of hypoxemia is due in part to an increased resistance of the upper airways which, due to anatomical deformity, are more restricted and increase the risk of respiratory infections and obstructions. A condition of chronic

hypoxemia seems to be the main cause of the altered development of the dendrites of cortical neurons and of the axonal layer. Therefore the management of a child with down syndrome by an osteopath must be focused on a cranial treatment performed with an extremely gentle, conservative and non-invasive approach to promote respiration and reduce upper airway obstruction. (Handoll, 1998)

Thanks to this experience I have seen how to relate with a patient with Down's Syndrome and with his relatives. The approach to be taken is very different from that with other people without the trisomy 21. Thanks to the tutor's teaching and the deepening I have done, I have been able to understand what are the contraindications to osteopathic treatment and what are the limits of osteopathy in this case. Furthermore, I was able to know an aspect of pediatric osteopathy that I did not know. I think it is also essential to learn about this topic because every osteopath one day could treat a patient with Down's Syndrome.

During the fifth year of my studies I no longer had the opportunity to observe or treat a patient suffering from down syndrome. However I wanted to further deepen my knowledge about the physical treatment of these patients because the beginning of my work as an osteopath is officially close. During the past year I had seen the physical effects of down syndrome and how to pay attention to them during the choice of osteopathic treatment. I had also studied that osteopathic treatment was very indicated in pediatric age, especially an approach with cranio-sacral osteopathy. This year I decided to look in the literature for scientific studies about the actual physical treatment indicated for a patient with down syndrome.

Most studies focus on increasing muscle strength in the lower limbs. This is applied to both children and adolescents as well as adults (Cowley et al., 2011; Shields, Taylor and Dodd, 2008); Lin and Wuang, 2012; Shields and Taylor, 2010). Each study suggests different exercises, but they all have excellent results in increasing leg strength. This could be useful above all to improve the stability of the patella and to reduce its continuous subluxations (Shields and Taylor, 2010; Cowley et al., 2011). In addition to this, physical activity also produces a positive effect on improving the balance of patients with down syndrome. With regards to this, a study conducted on children added isokinetic exercises to physical therapy and an even more evident improvement was found regarding the general balance (Eid et al., 2017).

The fact that there are promising studies conducted on both children and adults, suggests that even in an adult patient with down syndrome, his strength and stability can be improved.

With these further investigations, if I were to be lucky enough to receive a patient with a down syndrome, I would focus on three fundamental points to keep in mind:
- congenital ligamentous hyperlaxity
- exercises to increase muscle strength and balance
- cranio-sacral osteopathic treatment.

(1300)

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LONG REFLECTION 2: Deep Vein Thrombosis

I have been treating this patient since November 2017. She came to ICOM Clinic complaining a groin pain. The final diagnosis was a chronic contracture of psoas muscle made after the anamnesis and found through palpation and evaluation. She was asymptomatic after four weekly treatment and she has been maintaining one monthly treatment for two months. She referred an unusual symptomatology last appointment. She had had two weeks before an acute severe pain as a cramp to the right calf with swelling, redness, burning and allodynia on the right leg. This symptoms had lasted for 6 days, then they had disappeared. She came to ICOM Clinic for her monthly appointment after one week and she still had the little sensation of a calf cramp. The right leg was still swollen at the physical examination, but it was neither red nor sensitive.

I immediately thought about a red flag: the deep venous thrombosis (DVT), which is an inflammation of deep veins due to a venous thromboembolism. Mainly and most common signs and symptoms of DVT are edema, leg pain, tenderness and warmth or erythema of the skin over the area of thrombosis. Epidemiologically, approximately one person in twenty develops a DVT in the course of his or her lifetime. (Patel et al., 2017). For these reasons I looked for the tutor quickly. At the very beginning the tutor asked the patient if she had never had the same symptomatology and if she had never made a doppler ultrasound of the lower limbs. The patient answered she had made it many years before and the operator had found some defects on vein's walls. At that point, the tutor and I decided to not treat the patient and to sent her to make another doppler ultrasound because of the possibility of a DVT. Venography is an invasive imaging technique and it's infrequently used, despite it's the "gold standard" for the diagnosis of DVT. The tutor and I

chose ultrasonography because is the most validated and accurate non-invasive imaging method in symptomatic patients (Bernardi and Camporese, 2017).

I felt surprised and a little scared when the patient told me her symptoms. That was the first time I had to handle and manage a possible vascular red flag. DVT is considered a red flag for osteopaths because it could develop in a pulmonary embolism (PE) which is the occlusion of a pulmonary arteria due to a large thrombus. Death from DVT is attributed to PE, which causes nearly 300.000 deaths annually in the United States (Ouellette et al., 2017;). If a manual therapist didn't recognise a DVP, the thrombus could travel to the lung during techniques on calf and could obstruct the pulmonary arteries. I was also sure about my hypothetical red flag and I felt relieved when the tutor agreed with me on not treating the patient. Nevertheless, I didn't know how I must said to the patient that I wouldn't treat her. Indeed, the tutor explained to the patient the severity of her symptoms.

I think the most important aspect of this situation has been that I recognised a possible DVP as a red flag. Indeed, the first thing to do during anamnesis and physical evaluation is find and rule out any red flags. Another positive element has been the tutor was agreed with me because I took into account all the clinical signs of a DVP. On the other hand, I didn't ask about previous similar cases or previous doppler ultrasounds. I should have thought in fact of patient's medical history should have demanded it.

In my opinion, my alarming reaction has been a comprehensible behaviour because it was my first time. I had learnt how recognise vascular signs and symptoms during medical semeiotic class, but I hadn't ever seen a real case of vascular disease. So, looking for the tutor has been the right choice because thinking to the patient's health is the most important thing. Furthermore, I am still a student and I am still learning how recognise and manage difficult or dangerous situations. Indeed, having a patient with these symptoms in ICOM Clinic has been a fortune.
In this case I learnt to manage a possible red flag and to make a real differential diagnosis of the lower limbs based on medical examination. I could have thought about patient's possible medical history referred to vein complaints. But I will always ask for previous experiences when a patient will come with an unusual and suspicious symptoms. Especially in case of vascular disorder in lower limbs. At the end, I learnt what I could say to a patient when I suspect a red flag, and I won't be embarrassed If I'll decide to not treat him or her because the patient's safety is the most important thing.

During the fifth year I continued to treat this patient. After having done the echodopller in the lower limbs, the patient returned to the clinic with the medical report. The instrumental examination showed that everything was normal and there were no signs of venous suffering, but only a strong right calf contracture was found. On physical examination, the leg was no longer red or sweaty, but was still slightly swollen and painful.

With the tutor I decided to set a precise treatment plan divided into two parts. The first step involved improving the drainage of the lower limb; the second part instead consisted of a direct work on the calf and on the muscular chain of the right lower limb.

In the first two treatments, I then performed pelvic floor and diaphragm inhibition techniques by adding gentle lymphatic pumping techniques. In these treatments the condition of the leg had improved a lot.

Subsequently, two other osteopathic treatments directed on the muscular chain of the right lower limb were sufficient. This work aimed to reduce the muscular load placed on the calf due to postural dysfunction of the whole lower limb.

Both the tutor and I were satisfied with the work performed. I was particularly pleased to have been able to set up an osteopathic treatment plan specifically tailored to the patient's needs. Probably when I will implement my clinical experience over the years, I will be able to achieve the same result even in less treatment sessions.

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LONG REFLECTION 3: Adhesive Capsulitis (Frozen Shoulder)

The patient is a woman 46-year-old, volleyball player. She came to the clinic complaining of a pain in her left shoulder for about 3 months with a strong diffused stiffness to the whole area. The pain she felt get worse especially in the flexion movements of the shoulder (combing her hair), intrarotation (lacing the bra behind his back) and abduction (bringing the arm above 90°). Being a sportswoman, she was always kept under observation with periodic visits for players at an agonistic level. She therefore presented no problems in physiological terms. Playing volleyball, she was asked if she was left-handed, but she was right-handed. So even sport did not justify this pain in the left shoulder which arose in a gradual and invasive way and without apparent cause.

After having made an ultrasound on the shoulder, the patient returned with the diagnosis of initial phase of adhesive capsulitis and tendonitis of the subscapularis. As it is a muscoloskeletal disorder to which different types of people can involve, I think it is useful to deepen the topic because, working as an osteopath, it is very likely to meet a patient with this diagnosis.

Adhesive capsulitis, also called frozen shoulder, is a condition characterized by pain and stiffness of the shoulder with progressive loss of both active and passive joint movement. The loss of passive joint movement is the main factor that allows to make differential diagnosis with other pathologies of the shoulder such as impingement, tendinitis, bursitis or calcification. The term primary adhesive capsulitis is used when there are no other injuries on the shoulder and there is an unknown and idiopathic etiology of the inflammation and capsular adhesions. With secondary adhesive capsulitis, on the other hand, we mean a series of concomitant conditions that involve shoulder stiffness (Roberts, 2017; Neviaser and Hannafin, 2010).

Four stages have been identified in the evolution of the frozen shoulder.

	SYMPTOMS	SIGNS	TIMING
STAGE 1	Pain referred to deltoid insertion and pain at night	Capsular pain on deep palpation Empty end feel at extremes of motion Full motion under anesthesia	Less than 3 months

	SYMPTOMS	SIGNS	TIMING
STAGE 2	Severe night pain and stiffness	Motion restricted in forward flexion, abduction, internal and external rotation Some motion loss under anesthesia	3 to 9 months
STAGE 3	Profound stiffness and pain only at the end range of motion	Significant loss of motion Tethering at ends of motion No improvement under anesthesia	9 to 15 months
STAGE 4	Profound stiffness and minimal pain	Significant motion loss Gradual improvement in motion	More than 15 months

(Neviaser and Hannafin, 2010)

The diagnosis of adhesive capsulitis is done mainly on the basis of three criteria: physical and clinical examination, exclusion of other diseases, radiography of the normal glenohumeral joint. On physical examination there is a progressive reduction in range of movement of the glenohumeral joint attributed to a restriction of the joint capsule. For this reason both the active and passive movement are affected despite the negative X-Ray. The movements that are first involved are extrarotation and abduction; subsequently also the intrarotation and the flexion get worse. The radiography is required to rule out other pathologies such as dislocations, arthritis, fractures, avascular necrosis or osteosarcomas. (Roberts, 2017; Lewis, 2015).

As regards manual treatment, several studies have been carried out; the interesting thing is that many authors came to the conclusion that it is better not to carry out manual treatments with specific exercises to reduce the symptoms more quickly. On the contrary, they prefer a supervised rest. For example, Diercks found greater long-term benefit in patients who had not been treated than those who received manual and physical therapy. (Diercks and Stevens, 2004). Carette et la. (2003) also did not reflect substantial differences between the group that received manual treatment from the group that did not receive it. Griggs, on the other hand, has found a great improvement practicing only stretching within the limits of the patient's pain, without perform any physical exercise or technical manipulation (Griggs et al., 2000).

However, in more recent studies the muscular strengthening exercises of the rotator cuff muscles combined with stretching were taken into account and gave excellent results.

Specifically, mobilization of the gleno-homerus joint is performed in all the axes of movements. The pendulum exercise is performed in flexion, abduction and circling positions. Finally, stretching exercises and strengthening of the rotator cuff with elastics and possibly light weights are carried out (Yang et al., 2007; Lewis, 2015; Rawat et al., 2017).

By deepening this topic I have thus gained more knowledge on how the diagnosis of adhesive capsulitis is performed and how the shoulder showes itself to physical and clinical examination. Although some past studies promote more rest than physical treatment, more recent studies have shown excellent results in range of movement and pain. In the future I will therefore have in mind how to diagnose an adhesive capsulitis in a patient. In the first instance I would not treat him or her, but I will have an x-ray done, to see that other problems are not concomitant. In the event that the final diagnosis was adhesive capsulitis, I will apply the scientifically validated treatment protocols in these articles.

During the fifth academic year we studied the frozen shoulder during the course of Osteopathic Medicine. We then analyzed the pathology from the pathophysiological point of view. In fact, adhesive capsulitis is an acute inflammatory process with an autoimmune onset that causes fibrotic changes (Neviaser and Hannafin, 2010; Ryan et al., 2016). The most accredited hypothesis concerns the acute inflammation of the joint capsule with consequent infiltration into the synovial fluid. All this, leads to thickening of the joint capsule due to the increased number of fibroblasts and myofibroblasts created by the inflammatory process (Neviaser and Hannafin, 2010; Ryan et al., 2016). There is therefore an excessive production of collagen which causes the reduction of the movement of the joint (Ryan et al., 2016).

During the course of Osteopathic Medicine it was explained to us that in the first instance, we must consider a frozen shoulder as a red flag. This is because if there is an adhesive capsulitis in place, we are unable to interrupt the inflammatory process that has arisen in the joint. The best thing to do is to immediately refer the patient to an orthopedist who, with the administration of anti-inflammatories, will be able to stop the acute inflammatory process (Uppal, Evans and Smith, 2015). The osteopath must occur only after the acute inflammatory process has ended. If, on the contrary, a manual therapist decides to perform a treatment on the shoulder gilder even though he suspects an adhesive capsulitis, he

could further increase the ongoing inflammatory process. As a consequence there would be a much longer prognosis.

In light of this, I think I have a more specific and complete picture regarding adhesive capsulitis. In fact, if I met a patient in whom I suspect this disease, I would send it to an orthopedist who will make his most deepened assessments and he eventually will give the patient an indispensable anti-inflammatory therapy. Then, when acute inflammation has passed, I will implement the treatment and exercise protocols I had found during the past year to improve active and passive shoulder mobility.

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LONG REFLECTION 4: Lumbar Spinal Stenosis

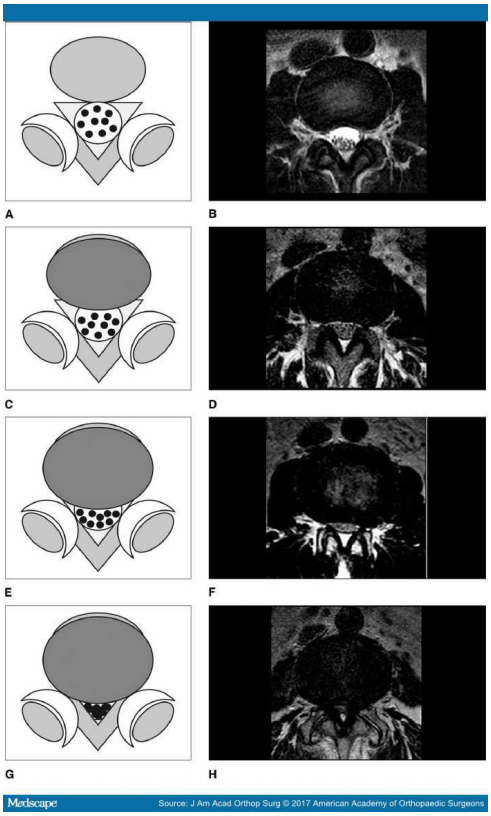
In November I visited a patient who complained pain in the lower limbs due to neurogenic claudication. This condition was caused by an initial compression of the medullary canal at the lumbar level, by bilateral herniation of the L5-S1 intersomatic disk and by a first-degree anterolisthesis. After having performed the first visit, the tutor and I agreed that it would be better not to treat the patient immediately in order to have an orthopaedic feedback first. The situation was quite disabling for the patient, so in order to promote his health and not worsen the situation, the patient was referred by an orthopedist who assessed the severity of the patient's clinical condition.

Lumbar spinal stenosis is a condition that is associated with patients with symptoms attributable to a reduction in the lumbar medullary canal. This diagnosis is made on the basis of precise radiographic criteria which, however, are not suffixed to establish the severity of the patient's symptoms. There are people with severe stenosis of the medullary canal which are completely asymptomatic.
Lumbar spinal stenosis is considered primary in case of congenital anomalies or postnatal pathological development, and secondary in case of degeneration, trauma or surgery. As for degenerative secondary stenosis, it may be characterised by a decrease in the anteroposterior or lateral diameter of the medullary canal secondary to a dehydration of the disk with or without hypertrophy of the zygapophyseal joints. Secondary stenosis affects people over 50, while the primary congenital affects younger people.
The main symptom reported by patients with lumbar spinal stenosis is the neurogenic caludication which causes symptoms in the buttocks, groin, thighs, and back of the legs up to the feet. In addition to pain there may be fatigue, heaviness, paresthesia, weakening,

nocturnal cramps and bladder neurological symptoms. Tendentially they are bilateral and symmetrical and there is not always a back pain. (Genevay and Atlas, 2010)

The simplest method for diagnosing LLS is based on on the study of axial T2-weighted images magnetic resonances. Grade 0 if the cerebral spinal fluid anterior to the cauda equina is not touched (figure A-B); grade 1 if the cerebral spinal fluid is touched but the cauda equina is not involved (figure C-D); grade 2 if the cauda equina is touched (figure E-F); grade 3 if the cauda equina is compressed and there is no distinction between its elements (figure G-H). (Lee et al., 2011)

Grade 0 indicates no foraminal stenosis; grade 1 indicates mild foraminal stenosis, which is defined as the loss of perineural fat in either the transverse or the vertical direction; grade 2 indicates moderate foraminal stenosis, which is defined as the loss of all perineural fat with no morphologic changes to the nerve root; and grade 3 indicates severe foraminal stenosis, which is defined as stenosis that results in a morphologic change to the nerve root. (Lee et al., 2010)



(Schroeder, Kurd and Vaccaro, 2016)

The primary aim of the management of lumbar spinal stenosis is the reduction of pain symptoms and the prevention of neurological problems. Conservative treatments including pharmacological treatments with analgesics, anti-inflammatories and antispasmodics, and physical therapy provide only temporary relief and are included in a general treatment applied before performing the surgery. In fact there is a low scientific evidence that proves the effectiveness of manual treatment in the reduction of symptoms and neurogenic claudication. Furthermore, there are few studies comparing conservative and surgical treatment. (Hsiang, 2018; Ammendolia et al., 2013; Ammendolia et al., 2014)

In an article the effectiveness of Stretching and strengthening exercises for lumbar, abdominal, leg muscles as well as low-intensity cycling exercises were evaluated. 45

patients were evaluated three weeks before and after physical program, resulting in a short-term improvement in pain and disability. (Goren et al., 2010)
In another article, two groups were compared. One program included manual physical therapy, body weight supported treadmill walking, and exercise (Manual Physical Therapy, Exercise, and Walking Group), while the other included lumbar flexion exercises, treadmill walking program, and subtherapeutic ultrasound (Flexion Exercise and Walking Group) . Fifty-eight patients with lumbar spinal stenosis were randomized to one of two 6-week physical therapy programs and testing occurred at baseline, 6 weeks, and 1 year. The authors came to the conclusion that people with lumbar spinal stenosis can benefit from manual therapy coupled with exercise in the short term. However, in the long run the symptoms often recur with the need for surgery. (Whitman et al., 2006)
Another article compares the surgical treatment with physical therapy. Surgical treatment is based on surgical decompression at the spinal cord level. Physical treatment offers lumbar flexion exercises, including posterior pelvic tilts, supine knee-to-chest and quadruped flexion exercises, stationary cycling or treadmill walking. Then lower-extremity strengthening exercises and lower-extremity flexibility exercises were performed. Finally the patient was educated to avoid postures involving hyperextension of the lumbar spine. Physical therapy was prescribed for 6 weeks, with a frequency of 2 visits per week. The authors concluded that the surgically operated patients and those who were candidates for surgery but did physical therapy, achieved almost the same results. However, the long-term outcome is not known, so it is not known whether physical therapy was maintained by patients or surgery was required. (Delitto et al., 2015)

After having received the consent from the orthopedist I have therefore decided to treat the patient explain what his clinical situation was and that the osteopathic treatment would not have completely solved his symptoms, but that would have improved it. However, being the patient overweight, he was also advised to follow a weight loss diet and was prescribed a parallel pharmacological therapy to osteopathic treatment to alleviate the symptoms.

During the fifth academic year, unfortunately I no longer had the opportunity to treat this patient. His symptoms had improved, but they had not disappeared. One day he was treated by one of my colleagues because I was not present in the clinic; after that day he never came back to ICOM clinic.

Speaking with my colleague who treated him, he didn't tell me any discomfort from the patient and any symptoms worsening. However, its symptomatology due to stenosis of the canal was quite important, so perhaps osteopathic treatment, combined with orthopedic prescription drug therapy, was not enough. One hypothesis is that the patient expected to be able to recover from his condition and, not having been so, he stopped the osteopathic treatment sessions.

This hypothesis has made me reflect a lot on my ability to give a correct prognosis to the patient and on not giving false hope to the patients. In my opinion, it is an aspect that is neglected in our university, but I'm sure it is one of the most important. Certainly the ability to deliver a proper prognosis will be acquire through years of experience. However, I will practice this topic in order to improve this aspect of my job.

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LONG REFLECTION 5: Gastroesophageal reflux disease

The patient is a 67-year-old woman whom I visited and treated during my clinical training. She presented to ICOM clinic with pain in the great trochanter's area in the right lower limb. The diagnosis of this problem was an initial arthrosic degenerative process of the hip. However her pain in the right hip was due to a functional overload given by an altered postural scheme both on the lateral and anterior-posterior plane. As for the lateral scheme the patient had a first pelvic degree with descending priority located in the D6-D9 tract. Instead, on the anterior-posterior plane, she had an abdominal priority. In fact, during the anamnesis, a very strong gastroesophageal reflux with hiatal hernia had been present for several years. Performing some osteopathic tests, I saw that the priority of both the lateral and anterior-posterior scheme was the hypogastric area. I practiced osteopathic treatments with the aim of reducing reflux and the whole posture of the patient improved, so she loaded less weight on the right lower limb and she had less pain in the hip.

Gastroesophageal reflux disease (GERD) is one of the most common gastrointestinal disorders among the population (Richter and Rubenstein, 2018). In Italy about 6 million people, which is 10% of the Italian population, suffer from GERD (Darbà et al., 2011). In Europe, on the other hand, the percentage of people suffering from GERD has increased from 15.2% in 2014 (Rubenstein and Chen, 2014) to more than 20% in just four years (Richter and Rubenstein, 2018). Although it is not considered a severe illness, it is one of the most common diseases in clinical practice (da Silva et al., 2012). Osteopathy is one of

the complementary therapies that some people seek trying to improve their conditions and in order to reduce or replace drug therapy (Michelfelder, Lee and Bading, 2010; Collebrusco, Lombardini and Censi, 2017). Since GERD has a multifactorial onset (Patti, 2018; Herregods, Bredenoord and Smout, 2015), the OMT present in literature is based on the treatment of different body structures.

The first part of the body that is taken into consideration during osteopathic treatment is the musculoskeletal component (Collebrusco, Lombardini and Censi, 2017; Snider et al., 2016; Young, McCarthy and King, 2009; Bjørnæs et al., 2017). From the structural point of view the spine is treated in three different points:

- cervical, due to the origin of the phrenic nerve which innervates the thoracic diaphragm (Snider et al., 2016; Bjørnæs et al., 2017);
- dorsal, for the orthosympathetic innervation of the esophagus and stomach (Collebrusco, Lombardini and Censi, 2017; Snider et al., 2016);
- lumbar, for the anatomical insertion of diaphragmatic pillars (Young, McCarthy and King, 2009).

From the muscular point of view, instead, primary importance is given to the diaphragm (da Silva et al., 2012; Carvalho de Miranda Chaves et al., 2012; Ong et al., 2018). This muscle is in fact also treated on its own through some breathing exercises. In some cases, breathing training or physiotherapy is suggested (da Silva et al., 2012; Carvalho de Miranda Chaves et al., 2012). Stretching or inhibition techniques are also performed on the diaphragm. The diaphragm treatment involves both work on diaphragmatic crura and insertion pillars (Ong et al., 2018).

The second part of the body that is treated is the visceral part which obviously includes the whole gastric tract (Bjørnæs et al., 2017; Diniz et al., 2014; Bjørnæs, Reiertsen and Larse, 2016) . The following structures are considered:

- lower esophagus sphincter and the cardia;
- the stomach with its small and large curvature;
- gastric ligaments;
- the pylorus.

Although the literature concerning osteopathic treatment for reflux is rather meager, the studies seem promising because they provide good results. However, treatment plans that include both visceral techniques and structural techniques provide better results.

Gastroesophageal reflux is one of the most common diseases, but it is not taken into consideration. As emerged from my modest clinical experience, a visceral problem has caused an alteration of the whole posture of the patient over the years.

(880)

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LONG REFLECTION 6: Idiopathic Scoliosis

The patient is a 48-year-old man whom I treated during the osteopathic clinical training. He did not complain of any pain or symptom. The only reason he required osteopathic treatment was postural control because he had idiopathic scoliosis. The patient had scoliosis from the childhood, however he never brought any orthopedic aids. Moreover, he could not define Cobb's angle because he had not performed any instrumental checks related to scoliosis for more than 30 years. However, he brought a chest X-ray in which a part of his scoliosis was visible. On physical examination the scoliosis started from the T3-T4 spinal tract and ended in L4-L5. The spine was divided into two parts: the first one

made a convex right curve that changed into a left convex curve through the dorsal-lumbar tract of the spine. Both side curves were very pronounced. Despite this, all the landmarks of the pelvis were aligned, and the clavicles have a very small misalignment. In his physiological history he did not report any respiratory or cardiac problems, but he suffered from heaviness in the stomach after large meals. The patient had practiced some exercises in the gym to maintain muscle tone and increase his aerobic endurance.

The main objective was to prevent the onset of respiratory or cardiac problems and to improve gastric problems. Furthermore, since this was my first case of a patient with idiopathic scoliosis, I decided it would be more useful to deepen this condition in order to suggest to the patient the best exercises to do to improve his posture.

Idiopathic scoliosis is the most widespread orthopedic pathology of the spine (Stokes, Sangole and Aubin, 2009). Its onset is considered insidious and his progression unstoppable (Pasha et al., 2019). Furthermore, its etiology is still unknown despite the presence of various theory. For this reason, it is defined as idiopathic (Stokes, Sangole and Aubin, 2009). The Cobb Angle is measured in order to define a scoliosis, which must be greater than 10° to be a real scoliosis. Cobb's angle also serves during childhood to define what consequences could occurred in adulthood (Stokes, Sangole and Aubin, 2009). Moreover, there is a classification of scoliosis based on age. There is the infant scoliosis until 3 years of age, young scoliosis from 3 years to puberty and adolescent scoliosis over the puberty age (Stokes, Sangole and Aubin, 2009; Schreiber et al., 2016; Pasha et al., 2019).

Different types of physical exercises have been analyzed and compared in the literature (Alanazi, Parent and Dennett, 2018; Berdishevsky et al., 2016; Borysov et al., 2016); the Scroth exercises are among these. The goal of Schroth exercises is to de-rotate, elongate and stabilize the spine in a three-dimensional plane (Kim and Hwangbo, 2016; Park, Jeon and Park, 2018; Schreiber et al., 2016). This is achieved through physical therapy that focuses on:

- Restoring muscular symmetry and alignment of posture
- Breathing into the concave side of the body
- Teaching you to be aware of your posture (Kim and Hwangbo, 2016; Park, Jeon and Park, 2018; Schreiber et al., 2016).

These exercises improved the function of the thoracic wall and the symptoms of the respiratory system, in fact they improve the trunk shape and respiratory ability by applying “rotational breathing” (Kim and Hwangbo, 2016; Park, Jeon and Park, 2018; Schreiber et al., 2016). This method is based on exercises tailored to each patient’s spine curvature. There is no specific standard of exercises, because they are customized based on the spine's curve of each patient (Schreiber et al., 2016). However, a session last generally 60 minutes and it is divided into three phases:

- preparation (cat walking and breathing exercise: 10 min) and stretching the chest part (5 min)
- the main exercise on muscular symmetry, rotational angular breathing and awareness of self posture (40 min)
- wrap-up (moving ribs: 5 min) (Kim and Hwangbo, 2016; Park, Jeon and Park, 2018).

Another manual and physical approach in case of scoliosis is the SEAS protocol (Berdishevsky et al., 2016). SEAS is the acronym for “Scientific Exercise Approach to Scoliosis”, a name related to the continuous changes of the approach, based on results published in the literature (Romano et al., 2015). This protocol of exercises in a different way than bracing: in fact, while an orthotic device aim to change the posture of the patient making it somehow fixed, exercises can determine behavioral and automatic changes of movement and posture (Romano et al., 2015; Morningstar, Woggon and Lawrence, 2004). This principle is based on the fact that the trunk and spine are driven more by automatic and feed-forward schemes than voluntary control. For the reason, active movement is more effective than passive positioning in determining changes of spinal deformity (Romano et al., 2015; Morningstar, Woggon and Lawrence, 2004)). SEAS exercises are based on autocorrection and stabilization because the improvement of spinal stability in active self-correction is the primary objective. However these two elements (self-correction and exercise) are not performed at the same time, but are carried out in succession. Self-correction is the true movement against misalignment (Romano et al., 2015). “Exercise” is added to self-correction in order to train the automatic response to maintain an optimal alignment through the widest possible array of challenging activities.

These are the two best thorough and most recent methods that exist in the literature used as conservative therapy in case of scoliosis to avoid surgery. The one most applicable by an osteopath is the SEAS method because the second method requires a further very thorough study. Both gave excellent results. However, the SEAS method is used as first

approach in adolescent boys, while Schroth exercises are also used in adulthood as they are very strong.

During this patient's visit, I did not asked what types of specific exercises he practiced in the gym. So in the future it will be essential to know what kind of physical exercises the patient have already performed. At first, I will treat the patient with the SEAS method. If there were no improvements, I would send the patient to a more competent medical figure able to perform the Schroth exercises. In the meantime I could think of deepening this method with possible specific courses.

(1100)

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Clinic Mapping Grid

Student name: Federica Terzi				
	Year 2	Year 3	Year 4	Year 5
Patient numbers per month	-	4	10	-
New consultations as practitioner	-	5	11	-
Intended new consultations as practioner	-	3	8	-
Observed new consultations	12	15	15	-
Number of returning different patient as practioner	-	20	53	-
Number of returning different patient observed	86	184	192	-
Total number of patients as practioner	-	4	8	-
Total number of patients as observer	45	66	140	-
Total number of student practioners at institution	240	180	160	-
Clinical Formative assessment	-	-	2	-
Total number of clinic hours per student				
OSCE	-	1	-	-
IELTs/ Equivalent	-	5	6.5	6.5
Signed by				
Total number of patients at institution	18.000	18.000	18.000	18.000
Total number of clinic tutors	40	40	40	-
Total number of students in clinic treating	145	130	140	-
Total number of students in clinic observing	140	130	112	-

FCA TABLE EVALUATION 1

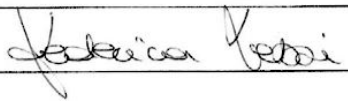
Date: 12/02/2018
Student name: Federica Terzi **Clinic tutor:** Luca Rizzi

	Mark 1-5 (1 worst, 5 best)		Student Development Areas and Reflection
	Student	Tutor	Reflection
CASE HISTORY TAKING			
BASIC:			
logical lines of enquiry	2	3	
Maintains flow	2	4	Between my marks and those of the tutor there is a noticeable difference. During a visit I'm not always sure I have asked all the necessary questions and I feel insecure. Despite this, the tutor has a better view of my skills.
Elicits facts;	1,5	4	
Comprehensive, clear & accurate recording of information	2	3	
Reflective completion	1,5	4	
APPLIED:			
In-depth knowledge of differential diagnosis	2	3	Self-assessing, I have considered the section concerning pathophysiology as the one in which I am most lacking. Despite this, up to now I have always been able to consider the pathophysiological aspects in each visit. Probably for this reason the tutor has assigned me a high score in this section while I have to practice more to make differential diagnosis.
Able to clarify and explain information	2	4	
Reasoned considerations of pathophysiological relevance	1,5	4	
Sensitivity to patient needs	3	4	
2. DIFFERENTIAL THINKING			
Demonstrates a reasoned association between case history & examination data (incl. considerations of anatomy, physiology, biomechanics, occupational, environmental, psycho-emotional & dietetic factors)	2	3	I think that the integration of data (physiological, anatomical, biomechanical, etc.) with the clinical case is one of the main aspects to be developed in order to formulate a correct diagnosis for the patient. To improve the execution of the differential diagnosis there I need for a lot of practice, time and effort.
Tissue differentiation	2	4	
Safety awareness	2	4	

3. EXAMINATION PROCEDURES **OSTEOPATHIC:** Appropriate selection & performance of exam routines	2	3,5	Both from the osteopathic and the medical point of view, the voice in which I assigned a lower score was the interpretation of the test results. In fact, I still have too little experience to understand and quantify the positivity of a test. Furthermore, as is also evident from the tutor's assessment, I have to improve the part of medical semeiotics.
Patient handling, palpation skills, patient comfort orderly sequence	2	4	
Accurate & effective recording	3	4	
Considered interpretation & relevance of results	1,5	4	
MEDICAL: System examination / clinical tests / performance, relevance & accuracy; orderly sequence	2	3	
Considered interpretation & relevance of results	1,5	4	
4. DIAGNOSIS / HYPOTHESIS FORMULATION Formulation of working diagnosis; hypothesis (incl. tissues causing symptoms, aetiology, predisposing & maintaining factors & clinical reasoning)	2	3	During a visit I do not think I can still formulate all the hypotheses that should be taken into consideration, but I think I'm at a good level.
Justification, knowledge & application of osteopathic principles	2,5	4	
5. TREATMENT PROTOCOLS **APPLICATION** Appropriate selection of techniques; accuracy & effectiveness of application	2,5	4	I'm satisfied with the treatment choices that I do because they are correct for most of the patients; however I know that there is still room for improvement. This thought of mine is confirmed by the tutor's assessment.
Adaptation of techniques according to patient	2,5	4	

PLANNING Identifies precautions & contraindications to treatment & responds appropriately	2	4	In the practical part, however, I still struggle to understand when the treatment change from short-term to the long-term. In fact, I often ask the tutor about it, but most of the time I can find the answer by myself.
Justifies short & long term prognosis	2	3	
Reasoned discussion of treatment aims (short, mid and long term)	2,5	4	
6. PATIENT MANAGEMENT Displays appropriate interpersonal skills	3	4	Regarding patient management, one of my future goals will be the collaboration with other medical figures; today I still can not establish a partnership with other professionals because I do not know them. I believe that the tutor has given mi a high score because since up to now I has been able to direct a patient towards some professionals (pilates and orthopaedic instructor) who work inside the ICOM clinic. It would also be interesting to partecipate at extra-curricular courses regarding nutrition so that I could give proper advice to patients about it.
Considers patient comfort / positioning during treatment application	2,5	4	
Identifies appropriate referral to other healthcare practitioners	1,5	4	
Adequately discusses diagnosis & treatment plan with patient	2	3	
Incorporates healthcare promotion (diet / exercise / further advice) in treatment planning	2	3	
7. COMMUNICATION & INTERPERSONAL SKILLS Professional appearance & demeanour. Demonstrates a considerate & caring & sensitive approach	2,5	4	Finally, I believe that maintaining an adequate professional attitude is fundamental to receiving the patient's trust and I am working hard to improve this aspect too.
Respects and responds to the needs of the patient identifies legal and ethical issues	3	4	
Displays good prioritisation & Management of time	2	4	

Clinic Tutor signature: 

Student signature: 

FCA TABLE EVALUATION 2

Date: 15/02/2018
Student name: Federica Terzi **Clinic tutor:** Nicolò Brambilla

	Mark 1-5 (1 worst, 5 best)		Student Development Areas and Reflection
	Student	Tutor	Reflection
CASE HISTORY TAKING			
BASIC:			
logical lines of enquiry	2	2,5	
Maintains flow	2	2,5	
Elicits facts;	1,5	2	I must surely become more confident of myself in taking a patient's history. However, being still in university I can definitely improve with practice.
Comprehensive, clear & accurate recording of information	2	2,5	
Reflective completion	1,5	2	
APPLIED:			
In-depth knowledge of differential diagnosis	2	2,5	
Able to clarify and explain information	2	2	Self-assessing, I have considered the section concerning pathophysiology as the one in which I am most lacking. Even the tutor did not give me a much higher score than mine, which means that he think I still have to improve a lot.
Reasoned considerations of pathophysiological relevance	1,5	2	
Sensitivity to patient needs	3	2,5	
2. DIFFERENTIAL THINKING			
Demonstrates a reasoned association between case history & examination data (incl. considerations of anatomy, physiology, biomechanics, occupational, environmental, psycho-emotional & dietetic factors)	2	2	I think that the integration of data (physiological, anatomical, biomechanical, etc.) with the clinical case is one of the main aspects to be developed in order to formulate a correct diagnosis for the patient. To improve the execution of the differential diagnosis there I need for a lot of practice, time and effort.
Tissue differentiation	2	2	
Safety awareness	2	2	

3. EXAMINATION PROCEDURES			
OSTEOPATHIC:			
Appropriate selection & performance of exam routines	2	2,5	
Patient handling, palpation skills, patient comfort orderly sequence	2	2	Both from the osteopathic and the medical point of view, the voice in which I assigned a lower score was the interpretation of the test results. In fact, I still have too little experience to understand and quantify the positivity of a test. From the tutor's scores I can deduce that in general I have to improve both osteopathic and medical examination procedures.
Accurate & effective recording	3	3	
Considered interpretation & relevance of results	1,5	2	
MEDICAL:			
System examination / clinical tests / performance, relevance & accuracy; orderly sequence	2	2	
Considered interpretation & relevance of results	1,5	2	
4. DIAGNOSIS / HYPOTHESIS FORMULATION			
Formulation of working diagnosis; hypothesis (incl. tissues causing symptoms, aetiology, predisposing & maintaining factors & clinical reasoning)	2	2	During a visit I do not think I can still formulate all the hypotheses that should be taken into consideration, but I think I'm at a good level. I think that the tutor also agrees with me about this topic because we assigned the same scores.
Justification, knowledge & application of osteopathic principles	2,5	2,5	
5. TREATMENT PROTOCOLS			
APPLICATION			
Appropriate selection of techniques; accuracy & effectiveness of application	2,5	2,5	I'm satisfied with the treatment choices that I do because they are correct for most of the patients; however I know that there is still room for improvement.
Adaptation of techniques according to patient	2,5	3	

PLANNING Identifies precautions & contraindications to treatment & responds appropriately	2	2,5	In this practical section the tutor assigned me a lower score than what I wrote. The score refers to the part concerning the short or long term treatment. He probably understood that it is one of my shortcomings in the practical part, and a lower score could encourage me.
Justifies short & long term prognosis	2	2,5	
Reasoned discussion of treatment aims (short, mid and long term)	2,5	2	
6. PATIENT MANAGEMENT			
Displays appropriate interpersonal skills	3	3	
Considers patient comfort / positioning during treatment application	2,5	2,5	Regarding patient management, one of my future goals will be the collaboration with other medical figures; today I still can not establish a partnership with other professionals because I do not know them. The tutor is in agreement with me because he gave me the same scores.
Identifies appropriate referral to other healthcare practitioners	1,5	1,5	
Adequately discusses diagnosis & treatment plan with patient	2	2	
Incorporates healthcare promotion (diet / exercise / further advice) in treatment planning	2	2	
7. COMMUNICATION & INTERPERSONAL SKILLS			
Professional appearance & demeanour. Demonstrates a considerate & caring & sensitive approach	2,5	2,5	Finally, I believe that maintaining an adequate professional attitude is fundamental to receiving the patient's trust and I am working hard to improve this aspect too.
Respects and responds to the needs of the patient identifies legal and ethical issues	3	3	
Displays good prioritisation & Management of time	2	2	

Clinic Tutor signature: Michele Bella

Student signature: Federica Terzi