Case Study #3

Background

Age: 48
Sex: Male
Handicap: 5
Height: 5'7"
Weight: 150lbs
Years Playing Golf: 20 yrs
Right or Left Handed: Right
Plays Golf: Right
Do they exercise currently: Does not exercise.

Medical History

The patient came in with right wrist pain during golf on the distal ulnar aspect.
The pain started 6 years ago while golfing and the pain comes and goes. He has not been able to play golf for the last two weeks previous to this examination. He has had 1 injection in the wrist that helped for a month.

Medical Exam

Upon examination the right forearm extensors, brachioradialis, and Pronator teres are tight and tender upon palpation. Wrist flexion is decreased by 15 degrees and extension decreased by 10 degrees. The supination press test is positive for a TFCC dysfunction. There is point tenderness and instability over the distal ulnar region where the TFCC is located.

MRI report was negative for any fractures or ligamentous tear. Swelling was present on the MRI.

Screen Results: (WNL =Within Normal Limits (12/2008)

Pelvic Tilt Test: WNL
Pelvic Rotation Test: Limited stability turning right
Torso Rotation Test: WNL
Overhead Deep Squat Test: Arms Crossed Limited and he places more weight on the right leg.
Toe Touch Test: Limited bilateral toe touch
90/90 Test: WNL
Wrist Four-ways Test: Limited flexion and extension in the right wrist.
Modified Thomas Test: Tight left hip flexor
Hip Abduction Test: Weak Glute Medius Bilaterally

Swing Findings

C-Posture at address
Sway during the backswing.
Golfer Slides during the downswing.

Plan

Treatment Plan: We built a corrective exercise program to correct dysfunctions in the pelvic/hip region that was leading to lack of involvement of those areas, increasing the demand of the upper extremity in the golf swing. We also started isometric strengthening and flexibility of the right wrist. We utilized Active Release Technique and Graston Technique for the adhesions found in the wrist and forearm musculature. Ice and electrical stimulation were used for palliative regions.

Exercises Prescribed: Exercises prescribed while golfer was in pain: Hip flexor stretch, Long turns with club, Torso turns one leg, wrist curls palm up/down, Stork Turns Supported, Torso Acceleration Drill, Wrist pronation/supination.
When pain had subsided, we added the step change of direction drill.

Swing: The golfer is a self taught low handicap golfer and I strongly recommend he seek the advice of a teaching professional. The golfer did not take my advice.

Summary

Our initial goal was to reduce the golfer's wrist pain, but secondarily and just as important, we need to address his lower body dysfunctions that were leading to over-use of his upper extremity in the golf swing. After 2 treatments with ART and Graston, his wrist range of motion was restored. After 4 weeks his wrist stability was essentially normal. After 2 weeks of treatment, he went pack to playing golf twice a week and he was able to play without pain. He did not pain during certain awkward movements during work. His lumbo-pelvic restrictions had drastically improved as well. At the time of discharge, the patient did not seek the advice of a golf professional like I had suggested.