

FUTURE FIT NEWS

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PRESIDENT'S MESSAGE

John Platero - *Founder, Future Fit*

2012 is here, and what a year so far!

Functional Training has been thrown around so long without a definition we might as well call it Life Training. Marketing is an essential component for any business to attract customers; however, as an industry when speaking to each other, we should have some consensus on what this term means. Or is it just a marketing term? Read the article and you tell me.

Our featured Personal Trainer is **Alexa Coombs**. She's new to the profession but I predict she'll be a great success story.

Did you know we have labrums in our hips? I thought we only had a labrum in our shoulders. Well, after two hip surgeries, I know better. Read about **Femoral Acetabular Impingement**.

Our greatest champions and our favorite heroes exist because they had to face extreme hardship, horrendous circumstances, and seemingly unbeatable odds; in many cases, even death. They are champions because they were able to summon the courage and intellect to take action and overcome these colossal adversaries.

Almost everyone has a story to tell, and in many cases your clients, or even yourself may be an unsung hero who

has looked "despair" in the face and risen above it. I don't proclaim to be a hero, but as you'll read in this newsletter, 2012 has presented me with the greatest challenges I have ever faced physically, emotionally and spiritually. I've learned that there is nothing a person can say to help alleviate the burden or help me heal. However, what does help, are people's actions. For me, it's peoples' actions that console and inspire. When a I say actions, it could mean, just being there. When you're physically weak or incapable to move, you find out who your true heroes are.

Every day we have the ability to console and inspire our clients. Words are nice, but remember, it's your actions of respect, caring and commitment to health that can make a difference. We all have the chance to be heroes and champions every day. What an amazing opportunity we each have..... The chance to lift someone's spirit or alleviate their pain..... Be thankful, nothing will make you feel more satisfied. Teaching, motivating and leading by example to live a healthy lifestyle is a powerful gift to bestow. Give it to everyone who wants it, God knows, we all need it.

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Femoroacetabular Impingement (FAI)

by John Platero

(AKA: Femoral Acetabular Impingement, Femoro-Acetabular Impingement)

What is it?

Femoroacetabular impingement or FAI is a condition of too much friction in the hip joint. Basically, the femoral head (ball) and acetabulum (socket) rub abnormally creating damage to the hip joint. The damage can occur to the articular cartilage of the femoral head, acetabulum or the labral cartilage. A labral tear is very common in FAI. The labrum is ring of cartilage that follows the outside rim of the hip joint. There is a labrum in the shoulder joint as well. The labrum acts like a gasket on the outside of the socket to hold the ball of the femur in place.

Hip problems in general often involve labral tears however, these tears are often secondary to abnormal hip biomechanics such as the labrum getting caught by friction between the bone of the ball (femoral head) and the bone of the socket (acetabulum) the condition of FAI.



FAI generally occurs as two forms: Cam and Pincer. Cam comes from the Dutch word meaning "cog," which describes the femoral head and neck relationship as aspherical or not perfectly round. This loss of roundness contributes to abnormal contact

between the head and socket. The Pincer form comes from the French word meaning "to pinch which describes where the socket or acetabulum covers too much of the ball or femoral head. This excessive coverage typically appears along the anterior-top rim of the acetabulum and results in the labral cartilage being pinched between the rim of the socket at the anterior femoral head-neck junction. Most of the time, the Cam and Pincer forms exist together- i.e., mixed impingement. *This is what I personally experienced.*

FAI is common in high level athletes, but also occurs in active individuals.

How is it diagnosed?

Excessive hip flexion with external rotation or excessive hip flexion with internal rotation places excessive compression and torsional forces on the hip, especially the labrum. As a competitive cyclist I'm used to experiencing joint pain and muscle soreness. Prior to my diagnosis I had recently increased my involvement with racing the velodrome. I had borrowed a track bike that was too small for me which put me in a hyper-flexed position. However, the smaller frame provided greater control on the track. Track bikes have a fixed gear so the cyclist can never stop pedaling. The races are much shorter and faster, so the cyclist is almost always in the drops or race position. Because there are no gears there is an incredible amount of torque needed to accelerate the bike. The pain I felt in my hips seemed as if it were tight hip flexors. I figured I just needed more rest and more stretching. I was already

competitive cyclist I'm used to experiencing joint pain and muscle soreness. Prior to my diagnosis I had recently increased my involvement with racing the velodrome. I had borrowed a track bike that was too small for me which put me in a hyper-flexed position. However, the smaller frame provided greater control on the track. Track bikes have a fixed gear so the cyclist can never stop pedaling. The races are much shorter and faster, so the cyclist is almost always in the drops or race position. Because there are no gears there is an incredible amount of torque needed to accelerate the bike. The pain I felt in my hips seemed as if it were tight hip flexors. I figured I just needed more rest and more stretching. I was already strengthening the antagonists to the hip flexors but, neither the strengthening or the stretching was helping. It finally got to the point where I couldn't ride at all.

Many people can be diagnosed with a good health history, physical exam, and plain x-ray films. Some believe that significant athletic activity before skeletal maturity increases the risk of FAI, but no one truly knows. There is usually a common complaint of hip pain (front, side, or back) and loss of hip motion. Plain x-ray films are used to determine the shape of the ball and socket as well as assess the amount of joint space in the hip. Less joint space is generally associated with more arthritis. In my case, I required an MRI of the hip. However, I had the first MRI without contrast. This was a mistake because it didn't show us enough. I had to go back and redo the MRI with contrast. This meant they had to numb my hips and then inject them with dye before the MRI was taken. The MRI with contrast is most helpful in eliminating certain causes of non FAI hip pain including avascular necrosis (dead bone) and tumors. A normal MRI does not preclude cartilage injury, labral tears, or FAI. After my second MRI with contrast, we discovered I had torn the labrums in both hips.

What other diagnoses might be confused with FAI?

- Hip Dysplasia (Adult Form)
- Lumbar Spine Pain (Low Back Pain)
- Lumbar Radiculopathy (Low Back Pinched Nerve, Low Back Facet Disease)
- Sacroilitis (SI Pain/Dysfunction, back of pelvis)
- Trochanteric Bursitis (Outside/Lateral Hip Pain)
- Piriformis Syndrome (Back of Hip Pain)
- Psychosomatic Pain Disorder (Stress Related Illness)
- Iliopsoas Tendinitis/Tendonitis/Tendinosis (Hip Flexor Inflammation)
- Groin Pull (Adductor Strain)
- Sports Hernia (abdominal muscle strain)
- Iliac Apophysitis (Front of Pelvis Pain)
- Quadriceps Hernia/Strain (Thigh Muscle Pull)
- Endometriosis
- Deep Gluteal Syndrome (DGS)
- Hamstring Tendinitis/Tendinosis
- Chronic Pain Syndromes

With what activities is FAI associated?

Some common activities:

- Ice Hockey
- Horseback Riding
- Yoga
- Football (American)
- Soccer
- Ballet/Dance/Acrobatcs
- Golf
- Tennis
- Baseball
- Lacrosse

continued

- Field Hockey
- Rugby
- Bike Riding/Cycling
- Martial Arts and Mixed Martial Arts
- Deep squatting activities such as power lifting
- Surfing
- Rowing Sports (Kayaking, Sculling/Rowing)
- Car riding, flying in an airplane (deep seated position, bucket seat position)

Why does it occur?

No one knows if FAI is a condition that begins at birth or develops during periods of growth. It is likely a combination of one's genetics and environment or activities.

How long can I wait before seeking treatment?

Typically, FAI that produces symptoms should be evaluated for surgical treatment. A delay in FAI treatment may compromise the cartilage of the hip.

Can I be treated with an injection of medicine or good physical therapy?

Generally, FAI is a chronic condition that does not typically respond to hip injections or physical therapy over the long term. I tried Platelet Rich Plasma (PRP) injections and it didn't help. That being said, a core strengthening program instead of hip stretching may be beneficial. In fact, stretching or yoga may make the symptoms worse.

Do I have arthritis if I have FAI?

Both plain film x-rays and MRI scans are an incomplete view of the cartilage inside the hip joint. It is possible and common to have good joint space on plain x-ray films and no signs of arthritis on the MRI and still have significant loss of cartilage within the hip.

Can my other hip be involved as well?

Yes, it is possible for both hips to have FAI.

What are my treatment options?

Non-operative management of FAI is possible; however, it involves a change in lifestyle from active to less active and a commitment to maintaining hip strength. Non-operative management will not change any underlying abnormal hip biomechanics of FAI and may contribute to further hip degeneration.

Operative management of FAI can be addressed via hip arthroscopy or open surgery. A hip arthroscopy involving labral debridement (no repair) and no bony decompression usually takes less than one hour. A hip arthroscopy involving labral/cartilage repair and FAI decompression may take between two and four hours, depending on the amount of work performed.

The open surgical hip dislocation approach can typically be done in a few hours. The open approach is not generally recommended in older patients, in patients with significant hip degeneration, or in patients with

significant athletic/activity demands.

Recovery time from most arthroscopic FAI surgical procedures is about three to four months to full, unrestricted activity. Your postoperative activity level will depend on your surgeon's recommendation, the type of surgery performed, and the condition of the hip joint at the time of surgery. FAI open surgery may involve a significantly longer recovery.

What are the main risks of FAI treatment?

- DVT (blood clot)
- Infection
- Hip Instability & Dislocation
- Femoral neck fracture
- AVN of the femoral head (dead bone)
- Heterotopic ossification (abnormal bone formation in soft tissues)
- Nerve injury (Sciatic, LFCN, Pudendal, Peroneal)
- Nonunion (open surgical dislocation only)
- Scarring/Adhesions
- Nonunion (open surgical dislocation only)
- Scarring/Adhesions

How do you rehabilitate FAI?

In the end, I had both of my hips successfully operated arthroscopically. Now I had to rehab them. Prior to surgery I visited five orthopedic surgeons, two doctors of physical therapy and spoke to a sixth orthopedic surgeon on the phone. All six surgeons recommended to ride the stationary bike within 48 hours of the surgery. This will improve the blood flow and maintain some mobility.

It's important that the hip joints stay in neutral. After surgery, you're given a hip fixator made of foam that velcros around your feet and hips so the hips won't externally rotate at night. In order to repair the labrums the surgeon places an anchor in the pelvis so they can sew the lambrum. They don't want you to pull that out by externally rotating at night.

Crutches are recommend for two - three weeks. For both surgeries I was on crutches for three days. I was able to weight-bear on the fourth day for each surgery so I started to walk slowly. Once the wounds had healed I went straight to the pool. I've had eight orthopedic surgeries and always successfully began my rehab in the pool. The water compresses the joint, you way weigh less and the resistance is accommodating.

Focus on range of motion. Stationary cycling and light gentle movements in the water are the best way I've found to rehabilitate orthopedic injuries. In the pool, do hip flexion, extension, abduction, adduction, internal rotation, external rotation, circumduction and walk. After about 10 days of stationary cycling and aquatics, you'll be ready to move to a land based program. Hip flexion will be painful at the start. Try to passively stretch the hip flexors. It won't be easy, but you must try. Concentrate on strengthening the hip extensors such as the glutes and hamstrings. The glute medius and minimus will be important to target as well; adduction and abduction can be done conservatively. Squats or lunges will be very difficult and will most likely cause pain. Start with partial range of motion as pain permits. As the range of motion improves and the pain subsides, continue to strengthen all the muscles surrounding the hips but be ever vigilant for tight hip flexors and internal rotators. Depending on where the surgeon made his

Rehabilitating is different than strengthening. It must be gradual and not that strenuous. It's more about fluidity of motion. Patience is a virtue. Don't worry, the body revives itself and you will come back. Sleep and good nutrition is a must. Your body will need more of both.

What is Functional Training and when should Trainers Implement it?

by John Platero

Recently I read an article in a fitness trade magazine regarding Functional Training. The writer called it a "New Trend." As I read the article, I realized the type of training she was describing has been around since Spartacus. It was just new to the author.

As an industry we need to market to the public for a couple of reasons. First, we need customers or we won't remain in business. Successful marketing should create interest in our products or services which will hopefully result in a purchase. Secondly, we want to help the public engage in a healthy lifestyle because in the end, all parts affect the whole. If we can help others stay healthy, we ultimately help ourselves.

We know marketing works. Is Functional Training a marketing term or is it really a type of training? For example, can we define aerobics? Jogging? Yoga? Mind body exercise? Plyometrics? I think we can. However, it is very difficult to settle on a definition of Functional Training. In general, this type of training is said to be more "real life." Body weight, stability balls, medicine balls, kettle bells, ropes, monkey bars, TRX and other assorted "toys" are spoken of as Functional Training. These modalities are often described as reaching beyond the scope of basic exercises. This leads me to believe functional training exercises are superior when it comes to function. However, these claims seem to contradict themselves. For example, a foundation of anything usually consists of the basics. However, anything above the foundation is superior or "above." In mechanics, a foundation or basic design always dictates its function. I mean, we could use a guitar as a hammer, but it won't last very long. (That was a joke.) Plus, shouldn't a person learn the basics before they progress to a more complicated set of exercises?



We function every day. We squat, lunge, curl things towards our bodies, curl out of bed, place stuff over our heads, pick things up off the floor and push and pull with both arms, or one at a time. Sounds like squats, lunges, curls, sit ups, over head press, dead lift, row and presses to me. These motions are often described as "primal movement patterns." I rarely see people in their normal day with one or two feet wrapped in a cord performing an exercise, standing on a dome-shaped ball lifting a weight, climbing on monkey bars, jumping on a trampoline or swinging ropes. Again, if you practice guitar, you become proficient as a guitarist, not a drummer or for that matter, a better parent. Of course, your sense of time, intonation and overall musicianship may become enhanced and

improve as a drummer. Maybe your hearing will become more acute and as a parent; you'll listen more. (Another joke!) However, according to the **S.A.I.D.** Principle (**S**pecific **A**daptation to **I**mposed **D**emands), the adaptations are specific. Hold on..... I'm not for one instant stating these functional exercises won't enhance function, but, as an industry speaking to each other--- should we define only those types of exercise as functional training? Are these exercises functional because they are not in a fixed plane? Walking is in a fixed plane -- predominately the saggital plane. Does that mean it's not functional? Are functional exercises superior because they are unstable? Most chairs are fairly fixed, especially the first chair you sit in the morning. Does that mean it's not functional? Are they better because they are multi-joint or compound exercises? So are squats, cleans and dead lifts. Are these basic exercises less functional than performing those same movements on a ball, a foam roller or strapped in a swing?

Almost every exercise can be argued to serve some type of function however, it's up the trainer or exerciser to determine what piece of equipment or "tool" to use to enhance that function. I just read this study <http://www.ptjournalonline.org/content/early/2008/02/21/ptj.20070045.abstract> entitled **Patterns During- Sit-to-Stand Task One Year following Unilateral Total Knee Arthroplasty**. The study concluded that the test subjects had weak quadriceps so they relied more on their hips to stand up. In essence, they weren't functioning properly. As they exercised and rehabbed their knees, the quadriceps got stronger but the altered movement patterns remained.

Here was their conclusion:

*The increased hip extensor moment demonstrated that subjects adopted a strategy to avoid the use of the quadriceps femoris muscle, yet this strategy persisted as the quadriceps femoris muscle strength improved. This pattern may be a learned movement pattern that **may not resolve without retraining.***

The same thing can happen increasing their strength or fitness in the gym. A person gets stronger, but unless *specific* retraining of the altered movement pattern is introduced, strengthening alone won't solve poor mechanics. Poor mechanics result in poor function which eventually leads to dysfunction. In essence, you have a stronger person functioning incorrectly. This is an important concept to always remember when exercising or performing any movements in general.

Many of the exercises or modalities called "functional training" are cool and a lot of fun. For most people, it's a new way to train and may cause members to stop and watch. Equipment manufacturers who sell these functional training tools or equipment use the term functional and have science to back it up. The industry changes so fast that they responsibly recommend we attend yearly seminars and workshops. Marketers and the press can also increase the demand for these new tools and programming. Some trainers and coaches are quick to use these tools. They may however lack the knowledge of biomechanics or progression to incorporate these tools, or, in many cases, may have too many participants to properly supervise them performing these challenging exercises. I myself have witnessed clients, who in an effort to keep up, compensate with an altered pattern to complete the exercise using the new tool. The client is now reinforcing a poor altered pattern or actually, creating another compensatory pattern without even knowing it. Good trainers can spot this. In order to correct these patterns, a trainer must

often use slow and controlled, isolated movement to reprogram their movement patterns. In fact, a leg curl, knee extension and a lateral raise are all single joint motions that are basic exercises and supposedly non-functional, however they are staple exercises commonly used to rehabilitate knees and shoulders to help people function properly in their daily activities.

I found a few definitions of the word functional:

- Functional - of or pertaining to a function or functions.
- Capable of serving the purpose for which it was designed.
- Constructed or made according to the principles of functionalism or primarily as a direct fulfillment of a material need.
- Designed for or adapted to a particular function or use.

What is Functional Training?

- Something you do in work, daily life or sport.
- Exercise that mimics work or daily life.
- Integrated movements are functional.
- If knee flexion is 90° or shoulder flexion is 120° you are "functional."

Orthopedic surgeons.

- Sport Specific Training versus Functional Exercise.

So what is it? Based on the definitions above, I believe, it is concept or mindset of applying exercise or force to our bodies. This concept can vary based on the goal.

As an industry, we need, and will keep evolving. Ironically, that can mean reviving older tools or techniques, in a fresh new way. Using "Functional Training" as a marketing term is effective for attracting new members and clients. If it succeeds in attracting new members or more personal training clients then the term has actually served its function! As a trainer however even vaguely defined, the concept of functional training is worthy of health and fitness professionals to incorporate it as a programming term. The fitness industry is so plagued with myths and misinformation, we must be careful to not mix the two, at least when we're communicating with each other.

I'm my opinion the fitness industry has never been better, or more informed. Exercise in general has the ability to increase function.

Professionally, or as a trade, we should recognize that these new (and not so new) tools and toys of **Functional Training** are just tools in the toolbox and if we're going to use them, we should know what to look for and how to progress. Have your trainers attend workshops or host workshops at your facility. Education is key, especially, with the modern day's level of fitness and the increasingly sedentary lifestyle that technology is leading us towards.

As an industry, we can help improve our members and ourselves; we must be careful though.... We don't want to market without substance. We are a service industry first and a sales industry second. When it comes to discussing exercise programming as a profession, I hope we're trainers that can sell, not salespeople who can train. We have to do both well; let's just watch the grey area so it doesn't get too blurry.

Most people need to begin exercising with the basics and progress properly from there. In exercise, everything is "load" or force



dependent. If your client is just picking a pencil off the floor, form isn't as imperative, unless of course they're picking it up 1000 times. As the load increases, form becomes more critical. Trainers should start their clients with stable, simple basic exercises first. Once the client has become proficient in these exercises, then gradually introduce different modalities. Here is a simple example of progression using a basic exercise:

- Start with a dumbbell press for example, regardless of whether your client is lifting dumbbells, kettle bells, a medicine ball with handle or a bucket of paint; lift with both hands with legs at shoulder-width wide stance.
- Progress to a staggered stance (one foot in front of the other, like a lunge stance) and press with both arms.
- Return to the original shoulder-width stance and progress to a single-handed or unilateral lift. Keep the dumbbells in both hands but only lift with one arm at a time.
- Now drop one of the weights and lift with only one arm at a time.
- Return back to both weights in both hands and stagger your stance and alternate upper extremities lifting with one arm at a time.
- Repeat the exercise above but drop one of the weights so you're only loaded on one side. Do a set with each arm.
- Return back to the wide stance and lift one leg off the ground. Begin by pressing with both arms.
- Now progress to lifting with one arm over the supported side; right foot is off the ground and right arm is pressing. However, you still have weights in both hands.
- Still loaded on both sides, progress to the opposite arm over the unsupported leg.

- Now, drop one of the dumbbells and repeat the same progression as above. Right arm over the right stance leg, then left arm over the right stance leg.
- Begin the entire sequence from the top with the non-dominant eye closed.
- Repeat the entire sequence with the dominant eye closed.
- Once your client can perform this entire progression, you can now add an unstable platform or surface, such as a BOSU ball, balance board, etc.

In general, functional training tools and exercises are fun, challenging and can definitely increase fitness, skill and function. They have their place for sure. Basic exercises are also functional and for most people, the basic primal movement patterns of squatting, lunging, bending, twisting, pushing, pulling and walking are the best place to start. If we attract new clients with the likes of balls, kettle bells, ropes, etc., let's be responsible enough to incorporate them gingerly until the clients master the basics. If not, you might end up in lawsuit, increase your liability insurance premiums and eventually jeopardize our credibility for fitness industry as a whole.

FITNESS TIP



The foot bones and ankle structure of sprinters are different from those of non-sprinters. In fact the foot and ankle construction in the fastest among us is similar to that of animals known for their speed, including cheetahs and greyhounds. According to a new study by Josh Baxter, a graduate student in the Department

of Kinesiology at Penn State University, sprinters have a long fore-foot (the part in front of the ankle) and reduced leverage in the Achilles tendon. These characteristics permit sprinters to generate greater contact force between the foot and the ground and to maintain that force for a longer time. Over a shorter distance like a sprint, this provides an advantage. It is not clear whether we are born with these traits or if they are result of training, but it is hoped that understanding this mechanism in sprinters can be applied to those who have difficulty walking.

FEATURED PERSONAL TRAINER Alexa Coombs



When you meet Alexa, it's hard to believe she was never athletic. "I hated sports when I was little." Although, she tried her hand at this and that, it wasn't until she was 16 and worked at Lassons Health Food Store that her interest in health and fitness began. "My schedule and easy access to great food forced me to eat small healthy meals every two hours. I had completely changed my diet and lost 20 pounds!"

Although Alexa had been a member of 24 Hour Fitness, she never really worked out. A friend, Dane and a personal trainer at the club began to teach

her how to train. "People at the gym began to ask me to work out with them, plus my Mother got cancer which forced me to learn how to help with that. This was a big factor. I wanted to help myself and help others."

A little over a year ago a man asked her to work out with him. He had broken his ankle and had been in a wheelchair. "He lost 30 pounds working out with me. It was so empowering!" However, Alexa didn't want to continue to train people without knowing what she was doing. As luck would have it, the Mother of one of her girlfriends, Karen Perlmutter, worked for Smart Fitness who delivers the NCCPT content and exam. Karen got her started and Alexa became certified. The next step, was to find a place to train.

A master trainer from 24-Hour Fitness opened his own facility called Ultimate Performance & Fitness in Westlake Village, Ca and invited her over. "There are about 20 trainers here at the gym and only four female trainers. I had to earn my way in. Everyone is real helpful and no one competes with each other."

Train and educate is her philosophy. "Some clients don't really want to know why they should perform a particular exercise. I try and educate them anyway." She currently works approximately 15 hours with most of her clients training three times a week.

Alexa trains herself 5-6 days a week. She'll train legs twice a week and then break up the rest of the body parts on the other days. She performs cardio six days a week and commonly performs intervals.

Alexa is currently in her last year at CSUN to complete her degree in nutrition. Her goal is to become a Registered Dietician.

Her passion for health and fitness exudes from her smile. It's infectious. She talks the talk and definitely walks the walk! For her enthusiasm and commitment to health and fitness we're proud to have **Alexa Coombs as the NCCPT featured Personal Trainer!**



Mufasa

The Angel Who Saved My Life

by
John Platero

On Friday night, February 12, 2012, I was out riding my mountain bike with my dog Mufasa. We normally do this twice a day once in the morning and once in the evening. We regularly do a loop around a college campus by our house. On our way home I exited from the college parking lot and saw a car coming. It seemed to be slowing down to enter the college parking lot. It was too dark to see the driver's face however, as I entered the lane to cross the street I realized he wasn't going to slow down at all! I quickly tried to pull Mufasa out of the way. Mufasa is a 90lb boxer and he resisted a little. He probably didn't understand why I would change direction when we were on our normal route home. I wasn't able to get us out of the way. I guess the driver never saw us because there was no sound nor screech, however I'll never forget the sound of the collision. He hit Mufasa first, sending him about 150 feet. Then he hit me..... It stunned me. I could see the headlights right above my head. I was hurting all over but all I could think about was my dog. Oddly enough, my cell phone rang but I ignored it. I couldn't see Mufasa and spotted him down the road trying to get up.... but he fell. My heart broke. How could have this happened? I immediately got up to run to him but fell to the ground. I had a fractured leg. I then started to crawl. I just kept saying "my dog, my dog." The man who hit me got out of the car and told me to stop moving and that I could be hurt. I just kept saying "my dog, my dog." I asked him to help me up, which he did, and with his help I hopped down the street. When I reached Mufasa I fell to the ground and started to speak to him and pet him. He was alive but freaked out. His eyes wide open and panting heavily he made no sound. No whimper or whine, he just stared at me. This all occurred within one minute. I reached into my jacket pocket and called my girlfriend Stephanie. I was lucky; she normally doesn't answer her phone. I told her what happened and hoped she would come soon. The paramedics were first to arrive. My hands were stinging, my shoulder and right leg were hurting, but it was my left leg that was killing me. It was huge and had a

big dent in it. The paramedics wanted to put a neck brace on me but I wouldn't be able to see Mufasa so I signed a document denying a neck brace. They placed me on a gurney but kindly left it low enough so I could keep talking and touching Mufasa. Luckily, Stephanie arrived with her Mother and helped with Mufasa. My leg felt like it was going to blow up, but all I cared about was Mufasa.

Mufasa was just over four years old. He was with me every day. He went to work with me, bike races, haircut, bike shop..... wherever I went, Mufasa went with me. He's been to Utah, Nevada, Arizona and all over California. When I won Nationals, he was there. When I slept in my van at Onyx Summit for altitude training he was there. When I got hypothermia at last year's Callville Classic bicycle race it was Mufasa who kept me warm in the van after the race. If it wasn't for Mufasa I wouldn't know any of my neighbors, the mechanics at the local gas station and most importantly, my wonderful girlfriend who was now at our side. My blood pressure was descending and the pain was getting worse and worse. The fire department and the sheriffs were at the site. One of the sheriffs asked the paramedic why my bike was so far away.....

My pain was increasing. We had to go. I asked Stephanie to take Mufasa to the pet emergency and to call me with whatever was needed. We headed out and in about two minutes my blood pressure dropped to 70/30! They hit the siren and in about four minutes I was being rolled into the emergency entrance of the hospital. The paramedics, Justin and Lindsay were compassionate, caring and gentle. I was very fortunate to have them. This kind of emergency had never happened to me before. A stove once blew up in my face but I didn't go to an emergency. As they wheel you in, a whole bunch of people start asking you questions. A doctor asked why I wasn't in a neck brace. I told him my neck was fine. He basically told me to shut up and let him do his job and I got a neck brace. Then the trauma surgeon came in. He introduced himself, asked a bunch of questions and began to check my trunk and pelvis first, then my extremities. My phone started ringing. I thought it might be Stephanie but it was my sister in Florida. Don't know why she was calling at 11:00pm her time but with everything going on around me I couldn't answer. I was going into shock. I started to shake and I was getting really cold. The phone rang again but it wasn't Stephanie so I didn't answer. I was embarrassed that my phone kept ringing while all these people were trying to attend to me. I had to keep it on in case Stephanie called. When she did, it wasn't good. A fireman had helped carry Mufasa to the back seat of her car while she carried his head. A student from the college offered to drive her car while her Mother sat in the front seat. Another student put my bike and her car and followed them to the pet emergency. Mufasa's heart had stopped in the car. As they arrived, Stephanie started screaming that his heart had stopped so they probably began a similar process that was occurring with me. Stephanie then asked



me for permission for the vet to do open-heart surgery to save Mufasa. I told her they could do whatever was needed; I didn't care how much it cost. They wheeled me down for a CAT scan but I was shaking so bad they couldn't do it. After they covered me with three or four really warm blankets I was able to stop shaking enough so they could do the scan.

Back to the emergency room where I lay alone with my neck brace on. "Please don't die, please don't die, please don't die," I repeated over and over. My phone rang again. I called for someone to please hand it to me. It was Stephanie but she couldn't speak. A voice came on the phone; it was the vet. Mufasa had passed. His spine had been fractured in two places and with all the internal bleeding he died. I just started to cry. It was the worst feeling I've ever had. I had lost my Grandmother and my Father but they were both older, had lived long lives and were unhealthy. This dog wasn't even five years old yet. He was the sweetest, friendliest, innocent, living creature I had ever known. Because of him I had met all of my neighbors and my girlfriend. He taught me how to be responsible for another living thing. He taught me the meaning of loyalty and unconditional love and friendship. If he hadn't been hit first, the man might have run me right over. Mufasa saved my life. I feel so guilty. He was better than me. He didn't deserve this. He was in my care and I put him in harm's way. He was just following his master like he always did; trusting in me. A wise older woman said that when horrific events like this happen we always tend to blame ourselves. What if I had just waited another 20 seconds? What if I'd gone a different way? What if I hadn't

been in such a hurry to get home? I go over those few seconds over and over in my head and it doesn't do me any good. I can't sleep and often just cry. A buddy of mine put it in perspective "you've done that same thing over a thousand times, it was an accident."

Stephanie's younger brother John surprised me and was the first person I knew to arrive at the emergency. He just held my hand. I was so sad. It was kind of him to come. Eventually, Stephanie came to get me and we went to see Mufasa. He looked like he was sleeping; no blood--- no scrapes. All I could do was cry in the nape of his neck where I could smell him. Over and over I told him I was sorry, I loved him and would miss him. I wanted to take back those few minutes. My friend Debra who always watched him when I travelled by plane came and said goodbye as well. I couldn't leave. I didn't want to leave him there. My body was killing me. My leg felt like it was going to explode. I cried and cried. Each step towards the exit felt like a mile. I felt like I would die of a hole in my heart.

I find myself wanting to sleep, because when I sleep I imagine he's alive. I can see his head at the foot of my bed waiting for me to wake, then following me into the bathroom where he patiently waits. He then studies me to see what footwear I'm putting on. As we go down the hall he happily scurries in front of me eagerly anticipating the day's adventures. If I go to my computer, he knows that will take a few minutes so he mozies up on to his chair where he settles in until I close the computer and grab my briefcase. As I exit the kitchen door to the garage, he curiously gives me that look "am I coming?" All I have to do is nod and he's out the garage door where he again patiently waits on the driveway for my cue. "Are we going for the ride, a walk or the van?" His greatest desire is to just be with me, no matter what, no matter where and no matter how long. It's hard to wake from such a beautiful dream. If it wasn't for Mufasa I might not be able to dream at all.

I love you Mufasa. I'm sorry. I will never forget you.

