In June 2017, I completed the Contemporary Practices in Injection Therapy module at the University of Nottingham. This course centred on the principles and practice of upper and lower limb peripheral joint and soft tissue corticosteroid injections. Upon completion, I am now qualified to administer corticosteroid injections to my patients under the regulation of our patient group directive. This course has further developed my understanding of the role of corticosteroid injections in the management of peripheral pathology. It required that I research the theoretical basis pertaining to injection therapy, whilst facilitating my anatomical and clinical reasoning skills that underpin injection therapy.

My personal reason for under taking this module was to deliver a more streamlined pathway for our patients. Peripheral injection is a common, if mildly controversial, tool in the treatment of peripheral joint pathology. A survey by Johansson et al. (2002) indicated that 96% of GPs and 94% of physiotherapists surveyed believed that steroid injection was an effective component in treating shoulder pathology. To be able to offer this treatment, as part of a wider conservative package, without having to refer to back to the GP, can only enhance the patient's treatment experience. It allows for continuity of care and avoids unnecessary input from multiple professionals.

If physiotherapists are to develop the self-referral model of care, then we need to be able to deliver a similar service as our GP colleagues. Completion of the Contemporary Practices in Injection Therapy module means that my injection therapy is clinically reasoned and is established on evidence based research. This is the foundation of effective patient selection for the delivery of injection treatment and will result in outcomes on a par with GPs.

I referred earlier to injection therapy as mildly controversial. Despite the popularity of injection therapy, very little is known about the way in which steroid injections may affect tendons (Dean et al., 2014). As a physiotherapist with an interest in research, the use of injection therapy throws up some interesting questions. What conditions are steroid injections appropriate for? How many injections are appropriate? How far apart? How long should patients rest following injection to maximise recovery? There is a minimum body of evidence around these topics and I am interested in developing a research question in this area. For example, degenerative rotator cuff tears; should we inject full thickness rotator cuff tears? NICE guidelines would tell us no, as it may have a detrimental impact on surgery. But what if our patient doesn't wish to have surgery? Does a steroid injection allow the patient to become more compliant with rehab? How do the outcomes for conservatively managed patients, with access to injection, compare with surgically manged patients?

Finally, I would like to take this opportunity to thank the MACP for their generous contribution towards the funding of this course. As a physiotherapist it is important to constantly challenge ones clinical reasoning and professional development. In our current age of austerity, where pay increases are well below inflation and employer budgets for training and development are non-existent, it is difficult to self-fund one's professional development. The MACP's significant contribution to this course is very much appreciated.

John O'Hora