Barral Institute Case Study

Visceral Manipulation – Bowel Symptoms

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Last treatment session: 10th May 2017

Presenting Symptoms

This 60 year old female presented with significant bowel symptoms. She reported a history of partial/full bowel obstruction which occurred monthly leading to severe pain, nausea and vomiting. Other symptoms included frequent uncontrollable diarrhoea during the day and night, abdominal tenderness and fatigue.

In 2012 she was diagnosed with rectal cancer and had a low anterior resection with a loop ileostomy, the ileostomy was reversed at a later stage. In 2013 she had further bowel surgery for adhesions which helped for 6 months until symptoms deteriated again. She had several episodes where her bowel had stopped completely and has to take morphine or be admitted to hospital. Other significant past medical history included a pulmonary embolism in both lungs in November 2015. In 2011 she was knocked down by a horse and had to have surgery for a brain haemorrhage. In addition to her bowel symptoms poor balance was a problem at times and she had difficulties sleeping as she was waking up frequently due to her bowel issues. She was leading an active life, living on a farm, running a caravan park and looking after her grandchildren.

Initial Evaluation

General listening (GL) was a deep listening, slightly to the left of midline and below the diaphragm. Local listening (LL) was to the superior mesenteric artery (SMA). On assessing the sphincters DJJ and pyloris were dysfunctional and on initial evaluation their motion was anti-clockwise. The neural plexi were also assessed and the celiac and inferior mesenteric plexi were dysfunctional with increased frequency of motion and erratic.

Treatment Sessions

The superior mesenteric artery was treated, medial to DJJ with an induction and elongation technique (towards ICV). The dysfunctional sphincters (DJJ and pyloris) were treated. The plexi, celiac and inferior mesenteric were balanced with each other and then the primary one DJJ was balanced with the left frontal lobe. The next GL and LL was to the splenic flexure which was treated and following GL changed to the right side and LL to the liver. Liver motility was low, 30-40% inspir and expir. The liver was treated using a liver lift and also anterior and posterior roll of the liver to affect the coronary ligament and the portal vein, the portal vein itself was also treated. In another session GL was emotional, falling posterior and manual thermal evaluation and inhibition confirmed that the pancreas was the primary area of listening. Local listening confirmed a restriction in the junction between the head and body of the pancreas with an extended listening to the stomach. Initially the pancreas was treated with associated organ (the stomach) in direction of ease. Then emotional treatment involved 'hooking' the pancreas from the frontal parietal zone a few times and this was followed using a non-verbal dialogue to help release the emotional patterning. In a following appointment another emotional GL linked to the pleura and this was also treated using 'hooking' from the right frontal parietal zone and a similar non-verbal dialogue technique.

In further sessions GL went to the right cranium and LLs to the tentorium, the jugular foramen and the vagus nerve (in the auditory canal) which were treated. During one session she had a flare up of a significant headache and GL went to the cranium with LL to the cranial dura, this was treated as were associated listening in the trigeminal nerve branches especially the ophthalmic branch (supraorbital) and the maxillary branch (infraorbital) and the headache significantly improved. In other sessions GL went to the abdomen with LL to superior mesenteric root, there was an extended listening to a loop of the small intestine and a double listening between these structures brought about a significant emotional release. In other sessions both the inferior and superior leaves of the mesenteric root of the small intestine were treated and also the whole mesenteric root was released from the posterior abdominal wall. The motility of the small intestine was treated with induction into ease. Other areas that were identified by GL and LL and were treated with visceral techniques included the duodenum (D1,2,4) the ascending colon, hepatic and splenic flexures, the transverse colon and the Canon Bohm area. The liver was also treated using the 3 planes of motion (direct stretch) and motility of the liver improved to 70-80% inspir and expir. The celiac trunk, hepatic artery and superior mesenteric arteries were all treated using elongation techniques to improve vascularity to the associated structures. She was also taught how to evaluate her sphincters and was trying to practice this at home to improve her digestive function.

Results

She attended for 8 sessions a month apart. Motility of organs had improved throughout the sessions particularly the liver, small intestine and duodenum. After the first session the day after treatment how bowel emptied and released a lot of old waste/toxicity which she felt was significant and beneficial. Her sleep pattern had improved and she was managing to sleep most of the night without getting up to empty her bowels and being awake for hours per night. She was still struggling with fatigue and her bowel was changeable between bouts of constipation and diarrhoea. During the time period of treatment she had 2 episodes of partial bowel obstruction but the frequency had significantly lessened.