

Barral Institute Case Study

Visceral Manipulation – Neck Pain & Thyroid

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Last treatment session: 18th May 2017

Presenting Symptoms

This 32 year old female presented with a 2 year history of left sided suprascapular pain and on occasion similar symptoms on the right side with intermittent episodes of neck stiffness. The symptoms were aggravated by doing gym workouts and she had to frequently stop going to the gym due to the pain. Gym sessions were limited to 30 minutes before provocation of pain, lifting weights overhead being the most provocative movement. In July 2016 she had a RTA but had developed symptoms prior to this. There was no other significant past medical history apart from low vitamin D levels.

Initial Evaluation

Initial general listening (GL) was to the anterior neck on the left side. GL from the upper limbs was to the same location. Local listening (LL) was to the left lobe of the thyroid gland. On palpation there was a large goitre on the left side of the thyroid gland which she explained had been there for a while and that her GP was aware of it. LL to the hyoid also confirmed a primary listening to the left lobe of the thyroid. The motility of the thyroid gland was diminished in inspir in all aspects (40-50%) on the left lobe. The pulses of the superior laryngeal artery (thyrohyoid junction) and the superior thyroid artery were very prominent on the left side compared to the right. There was a sensation of 'buzziness' over the middle cervical ganglia on the same side, the plexus was erratic and dysfunctional (increased rate). There was associated tension in the capsular tissue overlying the left lobe of the thyroid and there was limited sliding of the skin over the left thyroid gland with associated thickening of the dermal layers. Mobility testing of the mid cervical fascia demonstrated a fascial restriction over the left lobe of the thyroid with an extended listening to the omohyoid insertion on the left scapula notch and an associated listening to the left suprascapular nerve in the suprascapular notch. Active movement of the cervical spine reproduced some tension at the end of range, cervical passive intervertebral motion was limited at multiple levels particularly at C4, 5 and 6 to the left side.

Treatment

Initial treatment was to the left mid cervical fascia from the hyoid bone to the left posterior clavicle. Following this the left mid cervical fascia was released at the omohyoid insertion medial to the left scapula notch. The left suprascapular nerve was also treated. A skin rolling technique of the epidermal and hypodermal layers was used to stimulate branches of the vagus nerve over the left lobe of the thyroid, the patient was taught to do this self help technique for 2-3 minutes each day. The thyroid gland was treated with motility induction by encouraging expir.

In a following session the GL was to the posterior cervical spine on the left side. Local listening was to the cervical disc at C5 level. The C4 and C5 discs and the cervical nerve roots at these levels on the left side were treated. The mid cervical plexus was balanced on the left side. The visceral sheath of the neck was also treated initially in a direction of ease and then progressed to a direct stretch

technique. Further GL was to the anterior cervical region with LL again to the large goitre in the left thyroid gland. Motility induction of the left thyroid gland was used facilitating expir.

Results

Following two treatment sessions there was some initial improvement in her neck and suprascapular symptoms however she felt the benefits were short lived and still had intermittent symptoms. It was explained that her symptoms were likely to recur as there was a large goitre in the thyroid gland that was causing tension in the surrounding tissues. It was advised that she discussed the problem with her GP prior to a follow up session.