# Barral Institute Case Study

## Visceral Manipulation – Hip Pain

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**Symptoms/ Impairments:**
2/6/2023: HF is a 57 y/o F with complaints of L hip pain and tightness over the past year with more intensity of symptoms over the past 6 months. She feels that it's acting like her shoulder did when she experienced adhesive capsulitis in the past. She notes the pain is felt throughout the day but increases while lying in bed and first thing in the morning. She reports she cannot sleep on that side and also notices it while standing from flexion.

**Treatment and follow-up:**
Spinal ROM WNL except for 50% extension deficit, 25% R rotation, and L side bending deficit. Hypo-mobile through T/L junction and Ribs 10-12 bilaterally. Decreased bilateral hip strength, the most pronounced deficit in abduction and flexion. No complaints of radicular pain, faber, fadir, and repeat spinal loading do not modify symptoms. Initial GL from head to anterior RLQ. LL at midline from the umbilicus, inhibition point is cecum. LL at the level of cecum.
Yield primary restriction to inferior and inferior lateral parietal cecal ligaments.
Worked restriction with short and long levers using leg and psoas and re-assed. New GL to RLQ. LL inhibits the ascending colon. The medial wall of the colon is most restricted. Treatment to reduce restriction through the fascia of toldt.

Visit 2: Pt follows up 1 week later reporting no significant change in symptoms. GL at second session RLQ, LL inhibits to R kidney, LL at kidney, poor motility, severe restriction into expire with drift off from kidney inferior, lateral and posterior. Treatment to R kidney and balance with L kidney. Pt reports resolution of symptoms at the end of the session and instructed in hip flexor stretches bilaterally.

Visit 3: Pt returns 1 week later, and reports 20% return of symptoms at follow-up. GL at the head to midline above the pubis. LL at pubis inhibition at bladder with extended listening into urachus. Motility at the bladder is restricted by 50% to inspire. A direct approach to urachus. Second extended listening to L kidney through the ureter, double induction from the bladder to the kidney followed by stretch induction through the ureter. Instructed pt in nerve glide for ilioinguinal/hypogastric and genitofemoral nerve bias. Pt reports resolution of symptoms within the session.

Visit 4: 1 week follow up. Pt reports she had 4 good days but then her symptoms creeped back. Review of nerve glide for home was reviewed to improve performance. GL at the session was to RUQ, LL at midline inhibit to the liver, liver lift performed with induction until restrictions softened. New GL to the posterior thorax, LL at spine at t6 inhibition to R rib 5-6, treatment to the vertebral costal and costotransverse ligament. Motility induction to the liver. At the end of the session, pt reports the resolution of symptoms within the session. I instructed the patient to continue with nerve glides, hip flexor stretches, and modified sleep position. Pt spinal mobility is full at the end of the session and no longer hypomobile through the t/l junction.

Visit 5: 1 month follow up pt reports symptoms were resolved. She follows up because she overdid it in the garden and is now having plantar foot pain. Pt continued care for plantar pain and her anterior hip pain did not return while we treated the new complaint.

**Outcomes/Discussion :**

Pt demonstrated signs of entrapment at the lumbar plexus with symptom distribution consistent with its cranial branches. By resolving tension through the visceral system, adverse tension was resolved through the nerve pathways leading to resolution of the pain and return of normal lumbar ROM and hip strength.