Barral Institute Case Study

Visceral Manipulation – Back Pain

By: Jonathan Schehr PT, DPT, OCS

Symptoms/Impairments:
BF is a 53 y/o F with complaints of mid-back pain near her bra line, most pronounced on the R side. Pt notes she is R-handed. She had pain with deep breathing, turning in bed, and sleeping. She was in an MVA in April 2022. She had imaging after the accident. She notes that she was in therapy for 2 months which she feels helped her get stronger but did not address her complaint.

Evaluation:
3/31/23: Lumbar and cervical ROM within normal limits, Thoracic mobility within normal limits aside from severe restriction in L rotation and side bending as well as restricted rib expansion on L with inhalation. GL from head RUQ. LL from RUQ, hand sinks deep towards the liver. Extended listening from the liver towards the diaphragm strongly and more to L.

Treatment and follow-up: Pt was placed in a seated position for liver lift. Pt was taken through 3 inductions. During inductions, profound shearing motion through the coronary ligament and her body moved with significant amplitude while I followed the listening. During treatment pt demonstrated signs consistent with a vasovagal response and was carefully seated with back support, I increased cool air circulation in the room and sent for a BP cuff, water, and some food. Pt improved over the next 10 minutes and the mobility assessment before leaving demonstrated 50% improvement in L side bending, rotation, and rib expansion. She continued to report the same levels of pain.

4/20/23: Pt returns demonstrating maintenance of ROM gains but continues to report pain with deep breathing, sitting, and end-range rotation.

GL from head once again leads to RUQ toward the same region as previously.
Extended listening at the liver towards the diaphragm and L triangular ligament.
Seated techniques to improve mobility at coronary ligament and L triangular ligament. New GL from head continues to RUQ. LL is now more inferior and medial to the liver. Inhibition testing yields gallbladder with extended listening common to D2. Motility testing of the gallbladder yields restriction to expire. Induction to gallbladder, stretch to CBD and cystic duct, d2 stretch. Motility balancing to gallbladder, duodenum, and liver.

Pt left the session with nearly full pain-free ROM with continued but diminished pain with deep inhalation

4/26: Pt demonstrates continued maintenance of ROM gains and pain is only with deep inhalation

GL to R posterior throat. LL from the lower thoracic vertebra demonstrates costal vertebral and costal transverse restrictions between ribs 4-8 on R. Stretch induction to ligament/joint. New GL is more anterior and into the liver. A 3-d compression viscoelastic

technique was performed followed by motility induction. Following treatment pt reports no pain with deep inhalation.

5/19/2023: Pt follows up via email and notes everything is back to normal except for a small sense of stiffness with extreme forces and exaggerated inhalation.

Outcome/Discussion :
The liver is a solid organ and can absorb significant force during the events of an MVA. Pt previous treatment did not address the source of her restriction. Utilizing listening techniques as the guiding factor for manual treatment allowed this clinician to correctly identify the appropriate structures resulting in the resolution of symptoms.