

Barral Institute Case Study

Visceral Manipulation – Neck Pain & Headaches

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Last treatment session: October 2016

Presenting Symptoms

This 59 year old retired female was referred by her GP and presented with an onset of severe occipital headaches which developed 3-4 months prior to her initial appointment. The headaches were very severe (9/10 on the VAS scale) radiating into the temporal regions bilaterally, she also had significant neck pain. She had pain across the upper scapulae bilaterally and intermittent left medial arm pain to the wrist. Her significant past medical history included alcoholic cirrhosis of the liver; she had stopped drinking alcohol for 2 years. In August 2015 she had a history of haemoptysis and was diagnosed with variceal bleeding (linked to portal vein hypertension), treatment included several endoscopic variceal banding procedures over a number of months. She had a history of anxiety and depression.

Initial Examination

Her complexion was quite grey and slightly jaundice. She held her neck in a very protracted and flexed posture being unable to lift her head into a neutral position. Her neck movement was globally restricted in all directions, active cervical rotation was limited to 40 degrees and she had minimal cervical extension. The initial general listening (GL) was to the anterior neck on the left side. The hyoid, thyroid cartilage and cricoid cartilages were being pulled to the left, inhibition revealed the cricoid cartilage as dominant and the primary local listening (LL) was to the proximal oesophagus at C6. There was an extended listening to the lower oesophagus at the gastrooesophageal zone. The cardiac sphincter was also 'frozen'. Motility of the oesophagus was markedly restricted in both inspir (<20%) and expir (30%).

Treatment

Initial treatment was to the oesophagus in a supine position releasing two segments of the oesophagus, a double induction of the proximal oesophagus at the conflictual level (at rib 2/3) and between the oesophagus at rib 2/3 and the angle of the stomach (advanced thorax technique). The dysfunctional sphincters, the cardiac sphincter and pylorus were treated with induction until a functional clockwise rotation was achieved. The oesophagus was also treated with motility induction encouraging the direction of ease (expir). In the following session GL was to the right posterior cervical spine with LL was to the C4 nerve root on the right. Extended listening was to the right phrenic nerve at sedillot's triangle, with a further extended listening from the phrenic nerve to glissons capsule of the right lobe of the liver

and also to the parenchyma of the liver. The right phrenic nerve felt 'hardened' on palpation. The common hepatic artery pulse was diminished. Liver mobility was significantly restricted in all ranges (coronal, sagittal and transverse motions < 25%). Motility of the liver was minimal with only 5% expir and 10% inspir. Treatment of the phrenic nerve was combined with cervical spine nerve buds of C3 and C4 on the right side, the left phrenic nerve was also treated to ensure balance. The celiac trunk, common hepatic artery and proper hepatic artery were treated to improve blood flow to the liver. The liver was treated using a viscoelasticity technique, the liver tissue felt dense and fibrosed particularly in the area of primary listening. The sympathetic trunk to the liver was treated on the right side at T8 and T9 at the rib heads. The liver was also treated using motility in the direction of ease, inspir and expir increased to 40-50% at the end of the session.

In the third session GL was to the left side of the posterior cranium, LL was to the jugular foramen on the left side, more specifically to the vagus nerve. The vagus nerve was released at the jugular foramen bilaterally. The next GL was to the anterior neck on the left and LL to the left vagus nerve in the carotid sheath. The vagus nerve was treated in the carotid sheath on the both sides; these listenings were likely to be linked to the previous oesophageal varices and banding procedures. Further treatment of the liver included viscoelasticity techniques and liver lift, using direction of ease initially and gradually progressing to direction of stretch as the mobility of the liver improved. The coronal, transverse and sagittal movements of the liver were treated initially in direction of ease and then into tension. Other liver techniques used included posterior roll of the liver and also specific treatment of the portal vein in sitting.

Results

After 6 sessions of treatment every 4-6 weeks she felt 70 -80% improved. Her overall complexion/colour was much better. Her headaches had settled, there was still some protraction of her neck but her head and neck posture was better, she felt it was easier to hold her head up and the sensation of 'heaviness' in her neck and shoulders had lessened. Liver motility had improved to 60-70% inspir and expir and neck range of motion had improved.