

# **Barral Institute Case Study**

## **Visceral Manipulation – Sternal Pain**

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Last treatment session: 26<sup>th</sup> April 2017

#### Presenting Symptoms

This 36 year male who is an acupuncturist presented with central upper abdominal pain (just below the xiphoid process) and also tenderness to the lateral aspect of the sternum bilaterally. Six weeks prior to the appointment he had got some food stuck in the oesophagus and since then had developed upper abdominal tenderness. Two weeks after this incident during martial arts training he had been accidentally hit in the left side of his chest. He had no previous significant past medical history

#### Initial Evaluation

General listening (GL) was to the left anterior thorax above the diaphragm. Local listening (LL) was to the left 2<sup>nd</sup> sternocostal joint. Thoracic passive intervertebral motion in extension demonstrated restriction at T2 level and mobility tests of the sternocostal and costochondral joints in sitting demonstrated restrictions of the 2<sup>nd</sup> and 3<sup>rd</sup> sternocostal joint on the left and the 2<sup>nd</sup> and 3<sup>rd</sup> sternocostal joints on the right side. The sternal compression test was positive with an osseous restriction at the sternomanubrial joint.

#### Treatment

The sternocostal joints on the left and right (2<sup>nd</sup> & 3<sup>rd</sup> levels) were treated in side lying, using localised stacking rotation and induction. An intraosseous technique was used as the sternal compression test was positive, longitudinal compression of the sternum was localised to address restrictions in the cancellous bone at the sternomanubrial junction.

The 2<sup>nd</sup> GL was also anterior, close to midline and at the level of the diaphragm, local listening was to the lower oesophagus. The mobility tests of rotation of the hiatus indicated a mild restriction, induction into ease followed by direction of tension was used. The long lever technique to stretch the oesophagus in sitting was used using movements of the thorax to help stack into tension and facilitate the release following the orientation of the oesophagus. The anterior projection of the gastroesophageal junction (GE) was balanced with the posterior projection of the GE junction to balance tensions around the cardiac sphincter. Sphincters were checked and all were functional. Motility of the upper and lower aspects of the oesophagus was used following treatment to balance the tissues and help with nervous system integration.

#### Results

Following the session, the sternocostal mobility and thoracic intervertebral motion tests had much improved. He described more of an 'openness in his chest' following treatment and was feeling less tender in the upper abdomen. He only required one session as his symptoms were fairly recent in origin and he reported feeling significant improvement following the initial session.

