



AOCOPM 2023 Midyear Educational Conference

Rapid OMT Techniques for Nontraditional Settings

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Dx: Acute Torticollis

Etiology: "my pillow fell off my bed"

Techniques: Seated ST and Muscle Energy

*assumes each patient has had a full workup including a ROS for red flags, reflexes, etc.

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Cervical Spine Treatment

OA

- *Seated suboccipital Release*
 - Cup occiput with 1 hand, other on forehead and give gentle axial traction
 - Wait for musculature to relax
 - Add in some ST at end

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Cervical Spine Treatment

AA

- *Seated muscle energy*
 - Fully flex head and neck then rotate into the barrier
 - Pt gently moves head to neutral while dr resists motion
 - Relax, move further towards barrier, repeat until no new barriers reached

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Muscle Energy Treatment

Typical cervical spine (i.e. C3-6)

- Pt seated with dr standing behind pt
- Dr's R index finger on PTP (C3), rest on side of neck, dr's L hand atop pt's head
- Take to barrier: in this case flex, SB and rotate L
- Pt gently straightens head vs dr's resistance for 3-5 seconds
- During period of relaxation, go into barrier (flexion, SB L, and rotation L)
- Repeat 3-5 times

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Still Technique

- Specific, non-repetitive articulatory method that is indirect then direct, and attributed to A.T. Still
- Used to treat regional and segmental dysfunction
- Can be done from seated, supine, or side-lying position.
- Adapt for pt and physician, applying concept

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Cervical Spine Treatment

Still technique (i.e. C3ER_RSB_R)

- Pt seated
- Dr's R index finger on PTP (C3), and rest of hand wrapped around side of neck to support
- Dr's L hand on top of pt's head
- Take where dysfunction already is and exaggerate: in this case extend, SB and rotate R.
 - rotate until you feel relaxation of tissues.
 - this removes strain from affected segment

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Cervical Spine Treatment

Still technique (i.e. C3ER_RSB_R)

- Push down on head with L hand (axial compression)
- Move head away from area of dysfunction
 - Rotate head to L
 - SB L
 - flex c-spine
- Take to barrier - may feel release with monitoring hand
- Release compression, and take pt back to neutral
- Retest

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Diagnosis: Upper back pain

Etiology: long haul flight – no acute injury

Techniques: Soft tissue, Still Technique, Muscle Energy

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Upper Extremity Rhomboid Stretch

Pt seated with dr standing facing pt

- Place finger pads on medial and inferior aspect of scapula
- Drape pt's arm over your forearm/shoulder
- Roll fingers under medial edge of scapula to apply traction to rhomboids
- Continue traction while exerting a lateral force against medial aspect of scapula
- Relax and reapply traction force 3-5 times

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Thoracic Cage Still Technique

- Pt seated (or supine), dr standing on side of tx
- W/ 1 hand, contact tissues btw rib angle and transverse process and spring anteriorly to feel for hard end feel
- W/ other hand, grab olecranon and induce motion in UE, so olecranon moves twd contact point of posterior hand, until motion felt at contact point

Now ADduct UE at shoulder until motion felt at contact point

- Determine if internal or external rotation at shoulder is freer motion
- Depending on which motion is freer, continue full circle of upper extremity
 - internal rotation freer: arc of motion = overhand throwing motion
 - external rotation freer: arc of motion = underhand throwing motion

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Thoracic Muscle Energy

i.e. T1-3 N RR SBL

- Pt seated
- Dr standing behind and to left of pt
- Palpate intersegment T2-3 with R hand and use L hand to control head and neck
- Rotate head and neck to L through T2
- SB head and neck to R through T2
- Have patient SB head and neck to L v your resistance for 3-5 seconds then stop
- Engage new barrier by increasing rotation to L and SB to R
- Repeat steps until no new barriers engaged
- Reassess

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Dx: Carpal Tunnel Syndrome

Etiology: Developed symptoms in 3rd trimester of pregnancy
Techniques: Carpal spread, soft tissue



from: Up To Date online

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Plantar Fasciitis

MFR of Plantar Fascia

- Pt seated, with foot on your leg
- Place thumbs of both fingers on sole of pt's foot
- Move thumbs in superior and lateral direction, while maintaining steady pressure
- Continue until you feel tissues relax

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Counterstrain

1. Find a significant tenderpoint
2. Establish a pain scale (tell pt it is a 10/10)
3. Wrap the patient around the tenderpoint
4. Reduce pain by 70% with small arcs of motion
5. Hold for 90 seconds
6. Passively return patient to neutral
7. Recheck the tenderpoint

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Flexed Calcaneus Tenderpoint (plantar fasciitis)

- Place seated pt's foot on your thigh
- Monitor tenderpoint while plantar flexing foot to reduce pain to 3/10
- Hold 90 seconds
- Return to neutral and reassess

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Standing Lumbar HVLA

- Pt standing, hands behind neck
- Dr. holds pt's elbow with one hand and with other, grasps opposite knee
- Then gently twist in opposite directions
- At end of exhalation apply HVLA thrust

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Dx: TMJ

Etiology:

- Trauma, overuse

Tx:

- MFR, ME

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Evaluation

Palpate joints for crepitans/clicks

Palpate ms of mastication (2-3 lbs pressure)

- one side may be tender v other

Range of motion

- active - pt opens mouth 3-6 cm, laterally 1-2 cm, and then retracts and protrudes mandible
- observe jaw movements for deviation

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Treatment

Muscle energy ("C" shaped deviation and for all muscles that move the TMJ)

1. Patient supine
2. Have patient open mouth slightly
3. Dr contacts the body of mandible on the same side of deviation with palm of hand
4. Induce a force toward the opposite side of the chin deviation
5. Have pt provide a lateral force with jaw (in direction of deviation) v your force
6. Hold for 2-3 sec.
7. Relax and establish a new barrier
8. Repeat until no new barriers
9. Apply principle of muscle energy to any of the muscles of mastication

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Isometric exercises

For "S" shaped deviations and muscular spasm/weakness

1. Have patient place warm towels over TMJ's for 10-15 minutes
2. Have patient resist their own motion
 - a. Mandibular depression and closure
 - b. Lateral deviation, in both directions
 - c. Retraction and protrusion
- d. Have patient hold resistance for 20-30 sec
- e. Sets of 10, twice a day

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Myofascial stretching

1. Bilateral stretch
 - a. Patient seated
 - b. Doc contacts both angles of mandible
 - c. Stretch caudally
 - d. May be modified to treat tissue tension in all planes
2. Unilateral stretch
 - a. Patient is seated with head turned away from side of dysfunction
 - b. One hand stabilizes the head while the other grasps the mandible
 - c. Apply a caudad stretch
 - d. This may be modified as needed to address other motion barriers

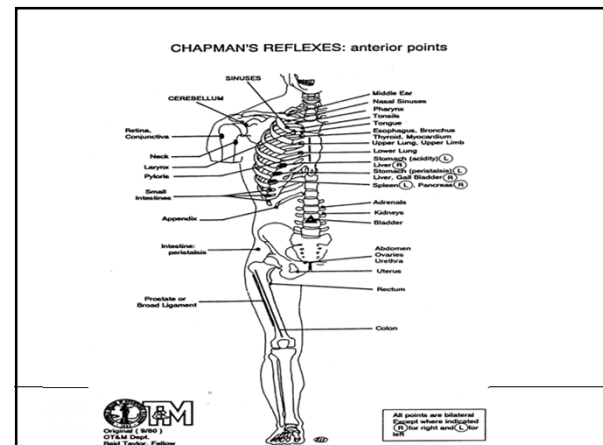
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Dx: Constipation

Etiology: travel, lack of water

Techniques: IT band release, MFR, cecal lift

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Iliotibial band release

- Pt seated with leg bent to place foot of affected side opposite on chair
- Dr standing at side facing pt
- Dr places one hand on the knee to stabilize
- Other hand placed on lateral aspect of knee and pressure applied to the depth needed to affect the dysfunctional tissue
 - use heel of hand, or flat part of hands
- Stroke lateral aspect of thigh to greater trochanter, maintaining pressure on the IT band

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Thoracolumbar Diaphragm Myofascial Tx

- Pt seated with dr behind
- Dr places 1 hand over right ribs 7-10 and other hand contacts left ribs 7-10 in midaxillary line
- Induce SB, noting restrictive barriers

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Thoracolumbar Diaphragm Myofascial Tx

- Induce transverse plane motion (rotation) noting restrictive barriers
- Apply direct myofascial release technique to barriers found
- After release of tissues, reassess region in same manner as above

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Mesenteric Cecal Lift

- Pt seated, slouching back
- Dr places heel of right hand on caudad part of RLQ
- Push cephalad
- Listen with hands and await tissue softening

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