

## Treatment Strategy

In osteopathy, it is sometimes difficult to find the restriction that is the key to the patient's problem. Should one first manipulate the skull, vertebral column, viscera, or limbs? Personally, I do not believe in the inevitable discovery of the primary restriction. There are so many possible causes that we can only hope to discover the "least secondary" of these, even if we refer to it as the "primary" restriction. Nonetheless, the order of treatment is important, and I would make the following suggestions:

Do not begin treatment by an adjustment of the vertebral column, but rather by cranial and visceral techniques. Vertebral manipulation should be performed only after you have tried to free all the other zones, better enabling yourself to find the primary vertebral restriction.

Always look for restrictions of the feet and the sacrococcygeal articulation. These are particularly pathogenic for the visceral system. The importance of the sacrococcygeal joint was discussed in Chapter 11 of *Visceral Manipulation*. I often find foot restrictions in patients with visceral problems. I can think of two reasons for this. One is the neurological connection: many abdominal and pelvic organs are innervated by nerves that also go to the lower extremities, and disorders in one area can therefore have a reflex effect on the other. There are also mechanical connections: visceral restrictions upset the balance of soft tissues which affect the stance and, therefore, the feet. Conversely, problems of the feet may have a cascade effect that upsets the mechanics of the viscera.

When there are several restrictions (particularly in the upper abdomen) or a large restriction (e.g., in the aftermath of peritonitis), general induction is usually preferable. For single restrictions it is better to

work locally. For example, if there is only a restriction of the sphincter of Oddi, you will obtain the best results by working on that area; however, if in addition the gallbladder and right triangular ligament are involved, you should use general induction and move your fingers slightly to work on all the affected areas.

With osteopathy, one begins with local treatment and ends with general manipulation in order to harmonize the reaction of the body. When you start locally, you can be relatively discrete and gentle (thus stimulating the patient's energy), and gradually involve more and more of the body. If a practitioner (particularly a beginner) starts right in with general manipulation, there is a tendency to work too suddenly and quickly; such treatment will exhaust part of the patient's energy without stimulating the self-healing mechanisms. In other words, if you start on a general or systemic level and make a mistake, you will dissipate the energy of the patient without obtaining results and therefore waste that treatment session. However, if you start locally you can gently correct any reaction of the body which you feel is unhealthy while the patient still retains enough energy to allow continuation of the treatment.

The general state of the patient's energy is a very important determinant of the success of the treatment. Of all the visceral manipulative techniques, motility is the one that interacts most with the patient's energy. For this reason, I end treatment sessions by working on motility. Of course, this does not imply that motility is more important than mobility, nor does it allow you to skip treatments for mobility. Without the ability to move freely and smoothly through its anatomical environment, an organ cannot attain good motility.

Osteopathic treatment should not be overly prolonged. Never ask a patient to

confirmed this many times. More importantly, the stomach regains its mobility and no longer opposes diaphragmatic movement. Through release of the diaphragmatic attachments, the muscle and nerve fibers supplying the stomach are stretched less. A prolapsed stomach means that the whole mass of digestive organs is prolapsed. This phenomenon triggers vasoconstrictive reflexes. The disturbed local circulation (particularly bad venous circulation) causes abdominal pain and digestive problems. Results from visceral manipulation are usually very good in such cases.

### *Recoil*

Recoil can be used when the stomach is unusually sensitive and prolonged pressure is painful. When utilizing recoil, you must treat all parts of the stomach that require work. It may be necessary to shift the focus of your pressure so that you can work on both the left and right parts of the stomach.

### *Mobility*

I would like you to review the different techniques discussed previously (*Visceral Manipulation*, pages 95-100). Here, I will describe several direct techniques specifically directed to the superior attachments of the stomach, which are very reflexogenic. These techniques consist of mobilizing the attachments on frontal, sagittal, and transverse planes.

## INDUCTION

Manipulation of the stomach mainly works with the following two areas:

- *Gastrophrenic attachments:* For this manipulation, have the patient assume the seated position. Apply pressure to a fairly large area of the superior part of the stomach to pull it toward the dia-

phragm. Then gently relax the pressure below the diaphragm. This technique comprises an induction of the stomach first and of the thoracoabdominal region second.

- *Lesser curvature of the stomach:* Place the palm of the hand on the area attracted by listening; stretch this area several times to stimulate its mechanoreceptors and then perform an induction. This is the most efficient technique for treating scar tissue from stomach ulcers. Generally, the palm slides toward the left.

When performing an induction of the duodenum, treating its descending portion brings about the best results, especially with respect to the sphincter of Oddi's projection.

Have the patient assume the supine position and stand on the patient's left side. First, push the duodenum several times toward the midline, which may cause some tenderness. Then perform an induction.

This should be a standard technique for treating:

- stomach ulcers and duodenal ulcers
- gastric and pancreatic reflux
- problems with the exocrine functioning of the pancreas.

## DIRECT FRONTAL TECHNIQUES

Have the patient assume the right lateral decubitus position, and stand behind her. Place both hands on the left hemithorax, with the palms below R5 and the fingers over the anterior costal margin. Mobilize the ribs in the direction of the umbilicus, gather as much of the stomach as possible and put it under the ribs, then stretch it obliquely in a superolateral and posterior direction by bringing your hands back toward you (*Illustrations 4-4 and 4-5*). Repeat this rhythmically, each time trying to gather more of the



ILLUSTRATION 4-4

*Direct Frontal Technique  
(Lateral Decubitus Position)*



ILLUSTRATION 4-5

*Direct Frontal Technique with  
Double Lateral Pressure*

stomach, until you feel a release. You then continue the technique by moving your hands farther down the ribs and repeating the movement.

Recoil can be performed when you have carried the ribs as far as possible toward the umbilicus. This is very effective because it enables you to free all the soft tissues on the left which surround the diaphragm, the ribs, and the pleura. I often do this two or three times when I begin treating stomach mobility. Alternatively, with the patient in the seated position, sit on her right side and surround her left hemithorax with both hands (*Illustration 4-6*). Strongly press the

ribs inferomedially while supporting the patient against you, and relax suddenly.

A sagittal technique with the patient in the right lateral decubitus position is also possible. Place your right thumb and hand on the posteroinferior part of the left hemithorax. The left hand is in front of the thorax pressing on the 7th through 9th costochondral cartilages. The posterior hand pushes the hemithorax forward while the anterior hand brings it backward, and then vice versa (*Illustration 4-7*). The gastrophrenic ligaments are thereby engaged. Recoil consists of waiting until both hands have moved as far as possible, and then re-



**ILLUSTRATION 4-6**  
*Direct Frontal Technique (Seated Position)*

leasing them simultaneously. This is an efficient and aesthetically pleasing technique as your hands are working separately. When

they are synchronized well, there is a perceptible beneficial effect on the body.

The direct transverse technique is also performed with the patient in the right lateral decubitus position. Place both hands on the anterolateral aspect of the left hemithorax, fingers toward the midline, thumbs toward the back. Both thumbs at the back mobilize the lower ribs, not toward the umbilicus, but toward the xiphoid process (*Illustration 4-8*). This technique has the advantage of mobilizing the posterior gastrophrenic attachments and the sternocostal articulations. Recoil occurs when the hemithorax is at maximal rotation.

## PYLORUS

### *Direct technique*

One direct technique for the pylorus is performed with the patient supine. When the patient has eaten recently, or is tense, the pylorus is found slightly to the right of the midline (*Illustration 4-9*), four or five fingers' width above the umbilicus. It will generally go into spasm as a result of any type of ulcer, or inflammation of the antrum or duodenum. Pyloric spasm stops gastric mobility and motility, and also brings about



**ILLUSTRATION 4-7**  
*Direct Sagittal Technique (Lateral Decubitus Position)*

These movements can be categorized into three main types (not counting the “emotional liver”):

- When the palm of your hand moves over the gallbladder without sinking in much, this points to a *metabolic liver*. These patients suffer from a liver problem due to indulgent eating, excessive drinking, certain medications, or drug use.
- When the palm of your hand moves to the right lateral side of the liver, this is an *inflamed liver*. You will find this in patients with hepatitis or, more rarely, with parasites. An interesting fact is that this area always has some kind of blemish. The memory of the liver cells is truly astonishing. Be sure not to confuse this result with listening for the hepatic flexure of the colon.
- When the palm of your hand obviously moves to the left side of the liver and even crosses over the midline, this is a *mechanical liver*. There is either a mechanical conflict between the gastroesophageal junction and the liver, or these patients had severe trauma, like a car accident or a fall on the back.

In *Trauma: An Osteopathic Approach*, Alain Croibier and I explain that, due to the oblique position of the heart, traumatic forces to the thorax mostly move toward the left side of the body. The highly elastic structure of the heart makes these collision forces rebound along the heart’s main axis. The left triangular ligament and the spleen are located along the way of these collision forces and suffer the consequences of the trauma.

#### *Adson-Wright test*

With hepatic dysfunction, this test is often positive, the pulse diminishing or disappearing on the right side, even without left rotation of the head. This positive result may be caused by tension of the hepatic fasciae. If the simple act of lifting the liver improves circulation of the right upper limb, you should look for problems of the liver, kidneys, and hepatic flexure. Remember that these organs are suspended from the liver. If participation of the liver is confirmed, systolic pressure on the right should be restored following successful treatment. In the case of a third degree renal prolapse (a kidney which has lost its attachment to the

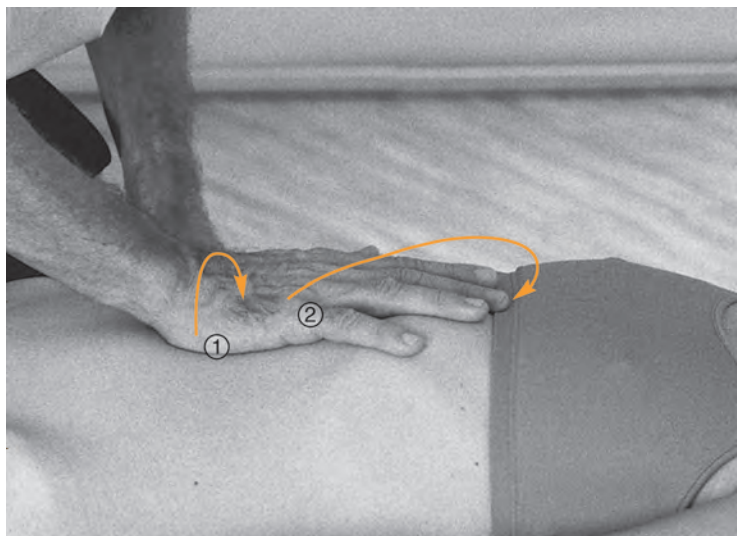


ILLUSTRATION 5-4

*Local Differential Listening Test*

1. Right kidney
2. Ascending colon (hepatic flexure)

liver), the hepatic lifting technique no longer affects it, and there will be no effect on the Adson-Wright test.

### DIAGNOSTIC MANIPULATION

The area between the inferior edge of the right ribs and the umbilicus is certainly one of the most complex to investigate and often requires inhibition techniques in order to render a precise diagnosis. I shall only describe some sample techniques, leaving it to the practitioner to apply these principles to the organs which are not mentioned.

#### *Inhibition*

As one example, let's say your hand is drawn toward the liver without your knowing whether the liver, gallbladder, or hepatic flexure of the colon is involved. With the other hand, look for the motility of the liver and fix it in its neutral position halfway between inspir and expir. If your hand is no longer drawn toward the liver, this could be the source of the problem. Inhibition of the motility in this manner is the most precise method of testing whether a certain organ is or is not the source of a problem.

Now, suppose that inhibiting the liver has no effect on the movement of the hand.

The problem then involves either the gallbladder or the hepatic flexure. Inhibit the surface projection of the gallbladder found on the midclavicular-umbilical line at its costal intersection. If the palm still moves upward and to the right, you can conclude that there is a problem of the hepatic flexure.

The inhibition technique can seem either simple or complex depending on the ability of your hand. It requires long apprenticeship and, once mastered, enables you to be very precise. If others are unconvinced, this precision can be objectively demonstrated using imaging techniques such as fluoroscopy, ultrasound, or scanning.

#### *Aggravation/relief*

With hepatic injury, the liver is often sensitive and congested. The simple act of limiting its mobility can aid diagnosis. Suppose that you are hesitating between diagnosing a problem of the liver vs. the pancreas. One technique that will help you determine whether the liver is involved is to press with one hand on the posterior angles of R7-9 on the right (*Illustration 5-5*). If there is no problem with the liver, there will be no discomfort. If there is a liver problem, this

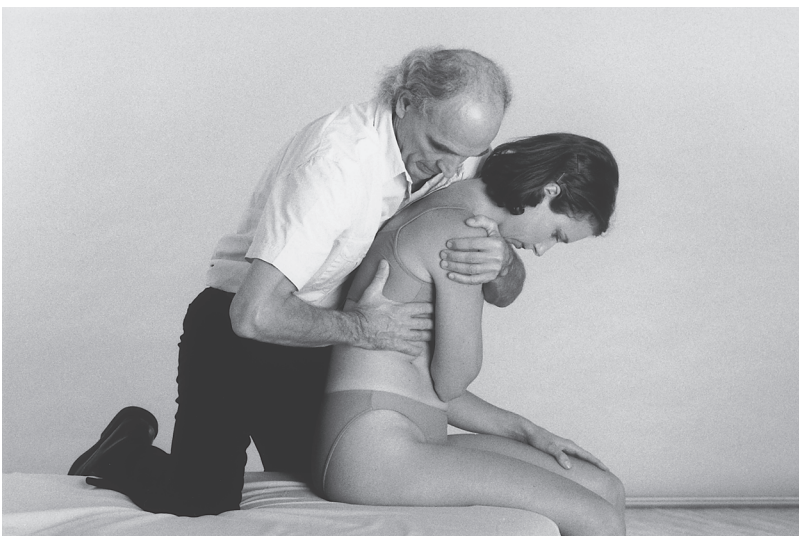


ILLUSTRATION 5-5

*Costal Pressure Technique*

pressure will be uncomfortable and even painful. Also, in patients with liver problems, as you follow the slight amount of motion that is there, respiration will become more difficult, and the sense of discomfort in the hepatic region will increase. In severe cases, the simple costal pressure causes the patient to hold his breath.

Relief maneuvers are less easily performed than those for the stomach. You can accompany the liver during exhalation and then maintain it. If this relieves hepatic discomfort, you can assume that the liver is the cause. But this would be to ignore all the organs suspended from the liver. I prefer to lift the liver, in conjunction with initial pressure on the posterior and lateral angles of the ribs. With hepatic problems, R7-9 are sensitive to this type of pressure. If the sensitivity disappears as you lift the liver, this supports the idea of hepatic involvement.

### *Lift*

Of all the viscera, the liver is certainly the easiest to move completely. The liver lift is performed with the patient in the seated position and the practitioner behind him. Utilizing the direct subcostal approach, put your fingers below the liver and lift it up (see also *Visceral Manipulation*, pp. 70-71). Immediate provocation of pain signifies that the actual hepatic tissue is affected. If pain is felt when the liver is passively returning to its original position, a problem of its ligamentary attachments is indicated.

With serious problems of the liver (such as hepatitis), Glisson's capsule, the liver, and its attachments all become sensitive. The liver lift is particularly useful in patients with chronic hepatic disorders, in whom the liver is heavier than normal and Glisson's capsule less supple; i.e., the liver itself is sensitive and so are its attachments (as they are strained by the increased weight).

## ASSOCIATED SKELETAL RESTRICTIONS

### *Thorax*

Restrictions of thoracic vertebrae and ribs are well-known and fairly characteristic with hepatic injury; they typically involve T7-T10 and R7-10. Costovertebral mobility tests are disturbed and compression of the spinal and transverse vertebral processes, or the posterior angles of the ribs, creates liver sensitivity. A primary costothoracic restriction does not permit any movement during mobility tests, whereas a secondary restriction of hepatic origin may permit limited movement. This relationship between the ribs and the liver does not only go in one direction; a direct fall on the ribs can result in lifelong hepatic problems.

### *Cervical vertebrae*

Liver problems often result in right or bilateral cervical vertebral restrictions (initially at the level of C4-5), while gallbladder problems usually lead to problems on the left. This ipsilateral restriction can be explained both by the interplay of the right cervical/pleural fasciae and the irritation of the right vagus and phrenic nerves. I am more and more convinced that relationships between liver injuries and cervical vertebrae restrictions are due to an irritation of the phrenic nerve, which innervates Glisson's capsule and the triangular and coronary ligaments. The phrenic nerve connects to the posterior cervical plexus which, in turn, innervates the capsules of the cervical articular processes and the intertransverse muscles. This may explain why C5-6 are restricted in patients with liver problems. Initially, these restrictions occur more on the right side and later become bilateral.

### *Glenohumeral periarthrititis*

Glenohumeral periarthrititis is found mostly