



## 10 Case Reports for VM1-4

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First Name	Ivy, Ka Pik
Last Name	Mok
Professional Title	Registered Physiotherapist (HK,UK)
Address Line 1	Room 1012, Fung Chak House
Address Line 2	Choi Wan Estate, Kowloon, Hong Kong
City	Hong Kong
State/Provence	N/A
Zip/Postal Code	N/A
Country	Hong Kong
Phone	+852 97709099
Fax	N/A
Email	<a href="mailto:ivymok.physio@gmail.com">ivymok.physio@gmail.com</a>
Profession	Physiotherapy

### **Case #1 Headache (non traumatic)**

#### **Abstract**

The intent of this case report is to explore the effectiveness of using Visceral Manipulation (VM) and Neural Manipulation (NM) for the treatment of a patient with 20 years of unresolved, cyclical, one-sided headache who also suffered from insomnia during the attack.

Key words: Visceral Manipulation, Neural Manipulation, headache, chronic headache, insomnia

#### **Introduction**

There are myriad reasons for one to have headache: hormonal, digestive, vascular circulatory, neural, food or even psychological factors (1). There haven't been much light (except from practitioners of VM) being shed on whether mechanical fascial or dural restriction would affect some of the above factors adversely, causing migraine headache. A slight increase in intracranial pressure (less than 5mmHg, for example), or impeded vascular circulation on

common carotid arteries, or vertebra-basilar arteries, could lead one to suffer excruciating headache. A restricted Tentorium Cerebellum (TC) has a very high prevalence to cause headache over the ipsilateral side of the frontal area due to its proximity with Trigeminal nerve (CN V) which supplies some motor and sensory aspects on the frontal area and the face. A restriction in dural membrane, which is not uncommon, may lead to impeded blood flow or congested sinus. These both could potentially alter the intracranial pressure, leading to increased tension intracranially and the symptoms of headache resulted. Depending on the location and layer of the restricted area, sometimes a restricted membranous tissue could lead to irritation of some cranial nerves, causing headache accompanied by insignificant but existent symptoms e.g. a irritated Vagus nerve (CN X) could affect the digestive system of the patient, yet the patient might not correlate the headache with the digestive issue. It was intended to understand if, by locating the restricted tissues through listening skills, and then by applying techniques of VM & NM, the neural and vascular components could find its way to a equilibrium and as such, whether the headache condition could improve or not.

## **Methods**

Patient was a 56 year old male choreographer and writer, a regular smoker, with over 20 years of cyclical, one-sided headache, most of the time on the left but this time it was on the right. The headache occurred usually once a month, last for a few days to a week. Soon before he came for treatment, the headache condition was getting intense which he described as “intolerable”. It also became severe nocturnally, rendering him suffering from insomnia during the headache attack. He tried many types of Chinese medicine treatment and also conventional western medicine yet the condition was not resolved. He perceived that the condition had a component of psychological factor relating to his parents but he did not talk much in detail. He was a regular smoker, he thought a lot due to his job nature. General health condition was uneventful.

### Dates of treatment: 2 March 2017, 28 March 2017

General listening (GL) was side bending slightly to right, very short, which stop at around occipito-temporal level, Manual Thermal Evaluation (MTE) in supine found out an emotional listening on pyloric area which was connected with the right frontal area. Local listening (LL) was on gastro-oesophageal junction. Cranial listening at vertex was to the right TC, close to midline, listening from Bregma was to right Trigeminal nerve (CN V) but also on right optic nerve (CN II), with CN V a stronger listening. Applying the tests of 3 witnesses of cranial restrictions, it was found positive test in saggital suture assessment, which confirmed the listening was on membranous level. According to a recent study (2), the rectus capitis posterior minor (RCM) muscle (forming part of the deep fascia) is directly connected to the dura via a myotendinous junction, and consequently to the reciprocal tension membranes, and from this muscle, we can locate if there is any tension on the dural membrane. Listening to dura through RCM was to right, slightly superior, which further confirmed the restriction should be on TC level. Tests on nerve branches of CN V on face showed restrictions to supraorbital & infraorbital nerves. Evaluation of the eye found increased pressure on intraorbital & optic

nerve. Assessment on optic nerve found restriction was lateral, very close to optic chiasm. Listening on vertebro-basilar arteries (VBA) on both and the left side was found to be of weaker pulse.

Treatment of TC with 3 steps were done on the right side for 2 times, followed by treatment on right CN V1 (ophthalmic nerve) & V2 (maxillary nerve), treatment on VBA was done on both side to achieve a balanced pulse on both sides. Cranial emotional listening was done with images and some treatment techniques on emotional part was done. Post-treatment GL was to the left on occipital level. GL on second treatment session changed to left side occipital level, LL on the body was on gastro-oesophageal junction. Extended listening (EL) was along oesophagus to the superior part of oesophagus. Cranial physical listening was to left TC. There was no listening on bregma. Listening from RCM showed left side superior. Assessment on vascular pulse of VBA was still weaker than the right. Assessment on CN V, optic nerve and 3 sutural assessment were done. With these, only saggital suture was still restricted. Treatment on left TC (x 2) was done, followed by VBA vascular treatment (x 2). Release of tension on gastro-oesophageal junction was done. Cranial emotional listening and treatment was done. Post-treatment listening was quite silent.

## **Results**

Patient reported of 80% reduction in headache after initial treatment, with no more insomnia and no further headache episode between first and second treatment. On second treatment session, patient reported of stomachache which was not too irritable and he attributed it to his irregular dietary patterns. He revealed he had poor relationship with his father and he felt he was not being loved in childhood and youth. After the second treatment, patient reported that he had 95% improvement on headache. There was no more insomnia and he did not report of stomachache during the course of treatment. He did not come back again for follow-up treatment, so it could not be confirmed if there was subsequent headache attack afterwards.

## **Discussion**

It is obvious that the maintenance of equilibrium of tension on TC and vascular circulation to the brain are crucial to keep the intracranial pressure constant and normal, which from this case, could relate to patient's symptoms of headache. Techniques on VM and NM and vascular treatment techniques are useful in achieving a balanced intracranial pressure.

## **References**

1. Barral JP & Croibier A, "Trauma: An osteopathic approach" Seattle, WA: Eastland Press, Inc. 1999
2. Bordoni Bruno, Zanier Emiliano, "Anatomic connections of the diaphragm: influence of respiration on the body system" in *J Multidiscip Healthc.* 2013; 6: 281–291.

## **Case#2 Left scapular pain**

### **Abstract**

The intent of this case report is to illustrate the effectiveness of using Visceral Manipulation (VM) and Neural Manipulation (NM) as treatment for a patient with insidious onset of left scapular pain on medial border, which referred up to left lateral neck and shoulder region. The pain sustained for 2 months with no favourable response from conventional physiotherapy treatment.

Key words: Visceral Manipulation, Neural Manipulation, left shoulder, scapula, upper back pain, neck pain, phrenic nerve

### **Introduction**

Clinical experience demonstrated that by only addressing the musculoskeletal or even the peripheral nervous system for treating shoulder or scapular problems are not exhaustive. We know there is a fascial and nervous connection between left shoulder or scapula with stomach, esophagus and pancreas (1). Concerning neural component, phrenic nerve is another structure that is indispensable for therapists to consider in treating patients with neck, shoulder or scapular problems, because the pathway of the phrenic nerve involves the entire brachial plexus and the entire cervical plexus (C1–T1) (2). Irritation of this nerve might often result in “referred” pain from structures being innervated by it e.g. visceral peritoneum of stomach, liver, gall bladder, glisson’s capsule, mediastinal pleura etc. On fascial level, Pre-vertebral fascia (i.e. deep cervical fascia DCF) might give restrictions to structures eg. phrenic nerve, and by releasing the tension on DCF, the phrenic nerve would be released and hence, symptoms arising out of the structures that were supplied by this nerve could be relieved. Bearing this in mind, if, through VM listening skills and mobility tests, the restricted visceral and fascial components involved for patient with left scapular pain were released, the mobility and motility of related organs could be optimized, the neural tissues were freed up as well, then the left scapular pain would subside, then it can further confirm that articular or musculoskeletal conditions would benefit from VM and NM, and that condition was told to be unresponsive to conventional physiotherapy modality.

### **Methods**

Patient was a 38 year old female journalist, who had regular sports activities e.g. long distance running and hiking. She developed left medial scapular pain which radiated to left side of the neck for 2 months prior treatment. She tried a few times conventional physiotherapy treatment with symptoms persisted. She also reported of pain in deep respiration. General health was good with no significant injuries reported.

### **Date of treatment: 14 December 2017**

General listening (GL) was forward bending, slight left side bending, below diaphragm. Local listening (LL) with inhibition showed the primary lesion was on gastro-oesophageal junction, with Extended Listening going superiorly, to the left very close to midline, very short and

stopped. Differential listening on nearby structures including the left triangular ligament of liver, the stomach were done, which confirmed the primary lesion be lower esophagus. Cranial physical listening at vertex was on the left side, postero-laterally, superficial with sliding feeling going down along cranial bones down to neck region. By inhibition, local listening on neck and mobility tests, DCF was restricted on left posterior aspect. Listening on Sedillot's triangle led me to the left, which indicated phrenic nerve there could be limited. Assessment on shoulder range of motion (ROM) showed not much difference. Neck ROM on left side bending & right rotation was mildly limited.

Treatment started by working on the gastro-esophageal junction, to free up its tension with surrounding structures, followed by a global technique of oesophagus (patient was seated, therapist's left hand on cricoid cartilage which is the top part of oesophagus, right hand on lower oesophagus subcostally, above stomach, right hand moved in caudal direction and released and listened to the tissue and followed) (x 3, 30-40 seconds each). Afterwards, mobility of oesophagus and stomach were assessed and treated. Restriction of DCF on left posterior side was released by local direct technique. Cranial physical listening was gone after treatment on DCF. Post-treatment GL changed to posterior slightly to left.

## **Results**

Patient reported on the next day that the left scapular pain (the pain was actually on T5 and T6 level, with T6 being the referred visceral level of stomach) subsided completely, and there was no symptoms in deep respiration. Left neck pain subsided as well. She felt great except that she experienced extreme tiredness and she did not want to eat for a day, as she felt good without eating. This just occurred for 1 day and she resumed eating with light food.

## **Discussion**

Instead of focusing on musculoskeletal system, we tried to approach left scapular pain with VM, by trusting the listening and as confirmed by mobility tests, to treat the structures and tissues with listening. Without addressing the musculoskeletal structure (as it did not have listening), the symptoms subsided with one session. It is proved again that treating the tissues with listening would bring in significant and long lasting effect.

## **References**

1. Barral JP, "Visceral Manipulation" Seattle, WA: Eastland Press, Inc. 2005
2. Bordoni Bruno, Zanier Emiliano, "Anatomic connections of the diaphragm: influence of respiration on the body system" in *J Multidiscip Healthc.* 2013; 6: 281–291.

## **Case #3 Right frozen shoulder, right neck pain, high liver enzymes reading**

### **Abstract**

The intent of this case report is to illustrate the effectiveness of using Visceral Manipulation (VM) and Neural Manipulation (NM) as treatment for a patient with insidious onset of right shoulder and neck pain, which was diagnosed by western medical doctor as frozen shoulder. The condition persisted for several months prior VM treatment. Patient sought treatment including traditional Chinese medicine, chiropractic treatment, conventional physiotherapy, all rendered temporary symptomatic relief yet the condition relapsed once the treatment stopped. Incidentally, patient also reported of increased liver enzyme readings on liver function test during annual body check.

Key words: Visceral Manipulation, Neural Manipulation, right shoulder, frozen shoulder, liver, neck pain, liver function test

### **Introduction**

Anatomy and dissection showed that there are always fascial, visceral and nervous connections on articular joints. Pain from liver and gallbladder disease are often referred to the right shoulder (2). For a right shoulder condition, one could not miss out structures such as liver (and its surrounding ligaments), gall bladder, cervical fascial layers, right phrenic nerve, etc. The phrenic nerve is derived from C3-C5 so that pain referral to the shoulder in a C4-C5 distribution is really a segmental pain referral (2). For right shoulder to have good range of motion (ROM) with pain free movement, the cervical fascia, especially the middle cervical fascia (MCF) and its extension, clavipectoral fascia must not be restricted, as these fasciae directly affect the joints of shoulder complex e.g. coraco-clavicular, acromio-clavicular, sternoclavicular joints. Through the anterior endothoracic fascia (the continuation of MCF on thorax level), the same fascia extends to diaphragm (3): the falciform ligament, the right and left triangular ligaments, represent a sub-diaphragmatic peritoneal thickening and both triangular ligaments (1), together with coronary ligaments of liver are closely connected to diaphragm, when these ligaments were in tension, or vice versa, when the diaphragm muscle is tense, the liver's movement would be affected adversely as well as the right shoulder complex. A special interest of this case is that, the patient, while having right frozen shoulder and right sided neck pain, was coincidentally found to have high liver enzyme levels in her regular body check on liver function test (LFT). Through applying VM and NM treatment sessions, we want to confirm not only if the right shoulder symptoms be improved or not, but also whether VM places a positive influence on the LFT.

### **Methods**

Patient was a 60 year old female who was retired and lived sedentarily. She practised pilates and yoga once a week. She developed right shoulder pain and limited movement (symptoms were around gleno-humeral joint and scapula), with right sided neck stiffness and soreness for around 6 months prior to treatment. She tried various treatment for symptomatic control with no long lasting effect. In recent body check, she was found to have high level of certain types

of liver enzymes in LFT. Hence she came and sought for treatment. Her general health was good with no long term medication required.

Dates of treatment: February 2017 - May 2017, treatment every 2 weeks, in total 8 sessions

During initial treatment, General listening (GL) was right side bending, slight forward bending, below diaphragm. Local listening (LL) with inhibition showed the primary lesion was on liver, near the base, projecting on right 9th rib sub-costally, with extended listening going superiorly. Differential listening confirmed it was not gall bladder nor lesser omentum but the liver being the primary lesion. Assessment on shoulder range of motion (ROM) showed right shoulder were limited in both external and internal rotation with internal rotation being more restricted (50 deg in supine, shoulder abducted position). Neck ROM on left side bending & left rotation was limited to 2/3 compared to the other directions. Mobility of liver was limited in all directions moderately. Direct techniques on mobility of liver in three directions individually was done, followed by stacking towards restricted barrier. Right triangular ligament in direct technique and technique with right arm as long lever was carried out, followed by liver lift to ensure coronary ligaments and also the zone on inferior liver (which is proximal to vagus nerve) are free. Hepato-duodenal ligament was found to be tense and was released. Afterwards, listening on cervical fascia confirmed MCF was restricted, direct and long lever techniques were done. Tension on clavipectoral fascia was found and was treated. Over the course of 8 treatment sessions, GL changed from right side bending and slight forward bend (i.e. liver), to left sided bending with slight forward bending (primary lesion changed to left triangular ligament after first two sessions, starting from 4th session, the primary lesion changed to stomach), in the following sessions, cranial physical listening was done with dural tension on cervical level of right side, and was released in successive sessions. Cranial emotional listening and manual thermal evaluation (MTE) were introduced in the last 3 sessions, with obvious emotional listening on liver, superior cardiac plexus and right frontal area (It would be covered in detail in another report for VM5&6).

## **Results**

Assessment on right shoulder and neck ROM was done right after the first treatment, the right shoulder ROM improved to 80 deg while the neck obtained full ROM. Apart from objective findings, patient reported of better sleep, but not much appetite to eat, particularly no interest in heavy food like fat meat etc. She felt the neck and right shoulder were symptoms free without doing any stretching exercise. In May, she underwent another LFT and to her surprise, the enzyme readings were all back to normal range.

## **Discussion**

Treating the liver using VM, freeing up the related fasciae and ensuring the mobility and motility of both liver and subsequently the stomach as well, resulted in right shoulder and neck full ROM and the increased liver enzymes readings were brought back to normal. It is provedn again that the mobility and motility of an organ is very important for it to function well and be healthy.

## References

1. Bordoni Bruno, Zanier Emiliano, "Anatomic connections of the diaphragm: influence of respiration on the body system" in *J Multidiscip Healthc.* 2013; 6: 281–291.
2. Cemil A Isbir *et al*, "A puzzling and rare cause of chest and shoulder pain: migrated foreign body to the spleen" in *Pain Medicine* 2012; 13: 1660-1661.
3. Paoletti S, "The Fasciae" Seattle, WA: Eastland Press, Inc. 2005

## **Case #4 Left knee pain & oedema (Baker's cyst)**

### **Abstract**

The intent of this case report is to understand the efficacy of using Visceral Manipulation (VM) and Neural Manipulation (NM) as treatment for a patient with posterior left knee pain and swelling for around 2 years. This report focuses on the effect of visceral manipulation on the symptomatic complaints of knee, with consideration on the play of visceral system to the knee.

Key words: Visceral Manipulation, Neural Manipulation, knee pain, Baker's cyst

### **Introduction**

Jean Pierre Barral said the knee is a neurological joint due to the fact that it has more nerves on knees than on other joints, e.g. hip (1). From orthopaedic point of view, Baker's cysts condition was considered as inflammation of the serous bursa of the muscles of the popliteal fossa. Barral & Croibier suggested that while this was partly true, they believed that quite often, the synovial problem has a mechanical origin, either on account of an activity or because it is hormonally induced in perimenopause (2). In assessing knees, Croibier suggested, "suspect a somatic dysfunction of the knee of the same side" if in assessing the knee joint and there was restrictions, blockage during your assessment (3). Assessing the neural component is necessary and there might be linkage of neural connection between an organ and the joint. If a kidney is not moving well, it can easily affect the joints of the lower limb, as the posterior pararenal fascia is in close connection with the nerves innervating groin and lower limb (iliohypogastric nerve, ilioinguinal nerve, genitofemoral nerve, lateral cutaneous femoral nerve). On the osteo-articular level, the knee has a lot of muscles, tendons and ligaments working congruently to provide stability for the joint. But if these muscles and ligaments are not in balanced tension, force being put on knee whenever in walking or sports activities would be changed and with time, the pressure would be built up on one part rather than the other. To maintain the synovial joint healthy, the mechanical component must be in harmonious motion in movement. VM techniques for knee is based more on the proprioceptive system to give the cerebellum as much information as possible, so that the movement pattern, the muscle firing actions of the joint, after treatment could change and hence the condition improved.

### **Methods**

Patient was a 50 year old male who was active in sports e.g. long distance running (over 10km) and playing tennis. Left knee pain developed 2 years ago prior he received VM, and he could not recall a significant injury. After TCM treatment for ~1 year, the condition became symptom free in normal daily activities e.g. walking, stairs walking. MRI was done at private orthopaedic clinic and he was diagnosed of Baker's cyst and mild inflammation on medial meniscus. Pain was provoked upon running over 5 km, which stopped him from long distance running and tennis playing. He practised stretching a few times a week with no significant result in terms of symptom control. His general health was good with no long term medication required.

Dates of treatment: 13 March 2017, 21 March 2017, 31 March 2017

Observation showed mild swelling on posterior medial aspect of the left knee. General listening (GL) on first treatment was right rotation, slight left side bending and forward bending, below diaphragm but above level of ischial tuberosities. Local listening (LL) with inhibition and differential listening showed the primary lesion was on omental bursa (or lesser sac), the bursa between stomach and left kidney, close to midline. The mobility and motility of both left kidney and stomach were limited mildly. Assessment on left knee's range of motion (ROM) was normal in extension and 20 deg reduction in end range of flexion as pain was elicited. ROM of left hip showed limitation on both external and internal rotation with internal rotation being very restricted (40 deg in supine, hip-knee in 90-90 deg position). Treatment was first on stomach and left kidney, to try to release the tension from the omental bursa. Techniques on lesser curvature, left posterior renal fascia, were done. Direct techniques and also long lever techniques in optimising the mobility of both organs were employed. Dural tube assessment by listening to RCM was done and it was found to have restriction on left lumbar spine level. Release of dural tube with long lever technique was done, followed by technique of left sciatic nerve and femoral nerve at hip level both longitudinally and transversely. By following listening, techniques on left knee, including mobilisation of the medial meniscus (was limited on both anterior and posterior directions), Pes Anserinus Profundus & Superficialis, fabella, oblique popliteal ligament were done as they were all significantly tight with fibrotic sensations upon assessments. Followed by release of adductor canal, left saphenous nerve on medial thigh level (around 3 or 4 fingers' width above knee), left sciatic nerve was checked and released. Left gluteal maximus was released. Techniques on four genicular arteries (lateral superior, medial superior, lateral inferior and medial inferior) and left popliteal arteries were done as well. Over the three treatment sessions, the treatment techniques employed were similar, the listening remained on the same spot but it became weaker and weaker after each treatment. Motility and mobility of the stomach and left kidney were always checked and treated in every session.

## **Results**

Post-first treatment assessment on right hip and knee ROM were done with right hip IR improved to 75 deg while the knee remained similar in end flexion ROM. ROM of both of these improved gradually and full ROM was achieved after the third treatment. Patient reported after the second treatment, he could run for 10 km without any knee symptoms as before. Although without any symptoms, patient reported that his TCM doctor always suggested that his stomach was not function well, yet he cared less as it was symptom free. After three treatment sessions, patient reported of full resumption of his long distance running routine without symptoms and he was discharged accordingly.

## **Discussion**

This case had some definite local articular issue as shown by listening and mobility tests on the tendinous and neural structures (E.g. Tightness of Pes Anserine Profundus and Superficialis, immobility of medial meniscus, listening on saphenous nerve). However, there was also a somatic component played on the condition. It would be important to consider

visceral and fascial components in treating even a joint with obvious local articular issue. The effect could be faster and more long lasting.

### **References**

1. Barral JP, "Understanding Messages of Your Joints: For the Prevention and Care of Joint Pain" Jean Pierre Barral DO 2014
2. Barral JP & Croibier A, "New Manual Articular Approach; Lower Extremity" FL: Barral Productions, 2016
3. Croibier A, "From Manual Evaluation to General Diagnosis: Assessing patient information before hands-on treatment" CA: North Atlantic Books & FL: Upledger Institute Enterprises, 2012

## **Case #5 Right hip tightness & soreness**

### **Abstract**

The intent of this case report is to understand the efficacy of using Visceral Manipulation (VM) and Neural Manipulation (NM) as treatment for a patient with persistent right hip tightness and soreness. Attention was drawn to the change of listening patterns on each successive treatment session which indicated how the tissues responded to treatment and that demonstrated the impact of visceral restrictions on musculoskeletal structure.

Key words: Visceral Manipulation, Neural Manipulation, hip pain

### **Introduction**

While one complains pain and limited movement on hip joint, the real problem could be unrelated to the articular joint itself, due to the fact that there are various components come into play in the "hip zone". The pain perceived by the patient could be "referred" from a tension on fascia, an internal organ, a neural structure, a vascular congestion. The reason for the "referral" of visceral pain is due to a lack of dedicated sensory pathway in the brain for information concerning the internal organs. The sensory neurons from the viscera connect within the brain with sensory pathways that carry information from the skin and muscles, and the brain interprets the signals that originate from internal organs as coming from the overlying skin or muscles. This is known as "viscerosomatic convergence," and it is thought to be the neural basis for referred visceral pain (1). To have a healthy and symptom free hip, the body systems that therapists need to consider include: cecum and kidney's mobility and motility, because of the proximity of these two visceral organs to psoas major and minor, the iliacus, the fascia of Toldt's, iliac fascia etc. The cecum attaches to the iliacus muscle, which works to produce flexion and internal rotation of the hip. If the cecum becomes stuck it can cause the iliacus muscle to pull towards the area of fixation. Like wise, psoas major is like the floor of kidney, for it to glide when it moves, restrictions of the renal fascia which wraps around the kidney, or fibrosity of the peri-renal fat would both obstruct the kidney's movement, resulting in psoas muscle tightness or dysfunction. Laterally, renal fascia also connects with transversalis fascia, which becomes part of the inguinal canal when it comes down to pelvic level, and if there is tension on deep or superficial inguinal rings, there might be some symptoms manifested on hip or low back. Neural system could not be missed on this area, five nerves are posterior to kidney that if they have irritation due to fascial tension etc, referred pain to groins, hips or thighs would be imminent. Vasculature is another thing that cannot be missed out. The inferior epigastric artery, femoral artery are the witnesses to confirm if some fascial tension on inguinal canal is released. If there is listening going to one kidney, consider also the other kidney due to the sharing of renal fascia, also ureters, bladder motility and mobility, and sometimes the urogenital organs e.g. uterus for women and prostate for men. Listening is the key to guide one to localise the tensioned area and to release the structure through indirect, direct and induction techniques.

### **Methods**

Patient was a 39 year old male who was a secondary school principal and who practised yoga, modern dance etc as his exercise routine. He developed right hip limited ROM and pain after taking a yoga class where he was being forcefully pushed into a pose, which stretched his right inner thigh. With three months of rest and self stretching, he hoped to have some relief yet

there was not much response, hence he came for treatment. His general health was good, except that there was benign tumour on rectum over 5 years ago that he underwent colonoscopy for removal of the tumour and other polyps. No known medical diseases was reported.

Dates of treatment: Mar, Sep, Dec 2017, April 2018, in total 4 sessions

General listening (GL) during the first treatment was right side bending, mild forward bending, below diaphragm, long listening around umbilical level. Local listening (LL) with inhibition showed the primary lesion was on right kidney. Differential listening confirmed it was not parenchyma but the renal fascia. Listening on Grynfeltt triangles led me to right. Extended listening (EL) was inferior towards right lateral bladder. LL on pubic symphysis was lateral to right, a bit rotation and it went posteriorly. Listening on sacrum showed positive in decompression test and it led to the same spot as in LL on pubic symphysis. Assessment on sacrum showed ligamentous limitation on right sacro-iliac joint. Assessment on lower limbs showed reduced ROM in both internal and external rotation of right hip, with internal rotation being more limited. Lasegue test showed it was limited to 60 deg with feeling of fascial pull at the back and such was released by inhibiting right kidney.

Treatment started by understanding the mobility of the right kidney, which was restricted superiorly and medially. Motility test indicated the right kidney might have second degree ptosis. Release of renal fascia from behind in side lying position was done, followed by release of tension between right kidney and psoas major, release of fascia of Toldt's, release of tension between ascending colon, D2 and right kidney. By listening and mobility tests, techniques on release of right piriformis, tensor fascia lata, rectus femurs straight head, obturator internus and externus, and release of tension on obturator membrane were done.

As patient tried to do self-stretching exercise for self-healing, the treatment frequency was sporadic. Over the course of 4 sessions spreading in one year, GL remained on right kidney with EL the same pattern. In third and fourth sessions, treatment was focused on right kidney and bladder, inguinal canal and vascular system. Right ureter was found to have tension and was treated following listening and induction. Superficial inguinal ring was slightly congested and it was released. Right renal vessels were treated, followed by right femoral artery, and nerve, and release of obturator nerve and foramen was done.

## **Results**

Assessment on last treatment showed normal right hip internal rotation and external rotation, Lasegue test on right was 80 deg. Test on sacra-iliac joints showed no more restrictions on right side. Both kidneys could move in synchrony with normal amplitude and frequency. Right kidney and bladder's mobility and motility resumed normal. There was no more tension on right ureter, obturator membrane. Patient reported of significant improvement after third and fourth treatment in terms of hip pain and tightness condition. On a side note, patient reported that he did not need to wake up at night for urination after third and fourth treatment.

## **Discussion**

Again, a seemingly musculo-tendinous tightness condition was actually due to a viscerofascial problem. The release of muscle tendons did not yield long lasting symptomatic improvement, or change in listening patterns on GL and LL. The focus on third and fourth sessions switched to the EL and it was the ureter. Without considering EL the mobility and motility of right kidney and bladder could not improve too much. This case showed the importance of how to formulate the treatment from focusing the GL area initially, to expanding the consideration to EL for a more complete and effective release.

1. Cemil A Isbir *et al*, "A puzzling and rare cause of chest and shoulder pain: migrated foreign body to the spleen" in *Pain Medicine* 2012; 13: 1660-1661.

## **Case #6 Chronic left shoulder, neck & hip pain**

### **Abstract**

The intent of this case report is to understand how visceral system affects the symptoms manifested on peripheral joints e.g. shoulder and hip, and the effect of Visceral Manipulation (VM) and Neural Manipulation (NM) on this kind of condition. Patient came for treatment due to left shoulder, neck and hip pain. Left shoulder and neck pain occurred around 1 year prior to treatment, left hip pain occurred 6 or 7 years ago, and it was aggravated in recent 6-8 months.

Key words: Visceral Manipulation, Neural Manipulation, left shoulder pain, neck pain, hip pain

### **Introduction**

The causes of a left shoulder, neck and hip pain could come from myriad reasons due to the complexity of the interconnectedness of the human body. Listening techniques in VM, followed by mobility tests could be one of the reliable ways to have more understanding on this issue. Cemil A, *et al* in (2) quoted Meller's words, "It is crucial to the effective treatment of chronic and persistent pain to have a better understanding of the mechanisms that underline the different types of hyperalgesia." It was suggested (2) that all pain types in the shoulder and chest region must be considered as a referred pain. We could interpret it as not just focusing on musculoskeletal or even peripheral nervous systems, but seeing a patient globally with all the systems being born in mind. One cannot have a symptom free hip if one's inguinal canal was congested, which could be due to tension on the transversalis and thoracolumbar fascia and that might be due to micro-rupture of diaphragmatic tissues. The transversalis fascia changed to endothoracic fascia, which is closely related to diaphragm, pleura, pericardium, lung and further up, the endothoracic fascia originates from deep and medial cervical fascia (DCF, MCF) (1). Hence, the DCF reaches the pubis via the transversalis fascia. Neck and shoulder cannot be symptom free if the pleura, the 3 pleural ligaments and the DCF or MCF has tension that eventually lost its ability to adapt. Bordoni & Zanier assumed that (1) "The phrenic nerve passes through the DCF and MCF, and be indirectly affected by superficial cervical fascia (SCF)". The phrenic nerve is derived from C3-C5 so that pain referral to the shoulder in a C4-C5 distribution is really a segmental pain referral (2). We want to understand if patient's peripheral joints symptoms, after being treated with VM and NM for achieving equilibrium on visceral, fascial, neural and vascular levels, would be reduced or not.

### **Methods**

Patient was a 58 year old male who worked sedentarily but was active in sports e.g. wake surfing, kung fu, yoga, swimming. He came for treatment due to irritable left hip pain. The pain persisted for 6-7 years yet it became worse after a non-displaced fracture of left little toe that got him change in gait inevitably. MRI to left hip joint showed degeneration and loss of cartilage of the joint. He also sought for improvement of the left shoulder and chest pain. Initially patient did not report of any major injuries in the past. Patient did not seek for medical treatment but he tried to engage exercise and see if it helped the condition. His general health was good, except that there was appendectomy over 20 years ago and helico-bacter pylori 8 years ago, treated with medication. No known medical diseases was reported.

Dates of treatment: Dec 2017 (2 sessions), April 2018 (2 sessions), June 2018 (1 session), in total 5 sessions

In first treatment, General listening (GL) was forward bending, long, slight right side bending, below diaphragm. Local listening (LL) with inhibition and differential diagnosis showed the primary lesion was on the fascia on the cecal area with lateral parietal-cecal ligament being tightest and it also had a tension with the iliac fascia posteriorly. Extended listening led to superiorly medial, on the umbilical level, between ascending colon and second part of duodenum (D2). Para-renal fascia was slightly tight on the right but it also affected that on the left, probably due to its structure being a reciprocal tension membrane.

There was a secondary lesion listening on the left parietal pleura close to mediastinal area (topographically just lateral to sternum on left side) (if the primary lesion is inhibited), which also gave an extended listening to the anterior endothoracic fascia (listening feeling was sliding, superficial, towards the left acromioclavicular joint and the cross along the left superior shoulder to the back side of shoulder above scapula).

Assessment on both hips' internal rotation was limited with left side a greater extent. Left shoulder was limited in both external and internal rotation mildly. Neck ROM in right side bending & left rotation was limited to 2/3 compared to the other side.

First treatment was focused on releasing tension of the cecum with the surrounding structures e.g psoas, iliac fascia, scar tissues from the appendectomy, fascia of Toldt's, renal fascia, This was to try to optimise movement among cecum, ascending colon and D2. Assessment on all sphincters showed dysfunction on ileo-cecal valve (ICV) but this quickly resolved after releasing the tension around cecum. Mobility of cecum, Ascending colon, D2 were ensured and treatment ended with motility of them. Both right and left kidney's mobility and motility were good after renal fascia was balanced.

The left parietal pleura was also treated, together with the MCF on neck, to free up MCF relative to DCF. Mobility test showed costo-pleural ligament was restricted, and such was released. Tension of clavi-pectoral fascia was released. Afterwards, treatment on trapezoid, conoid ligaments, suprascapular ligament and nerve were done. Sterno-clavicular ligaments and joints were treated as well. Over the course of 5 treatment sessions, GL changed from right side bending and slightly forward bend (i.e. liver), to left sided bending with slight forward bend (left inferior peritoneum, inguinal canal, and hence those structures were treated in subsequent sessions), in the last treatment, with GL & LL, the primary lesion was found on the fascia between D2 and ascending colon. In subsequent sessions, cranial physical listening was done with dural tension was located on right L1-2 level, which was released in subsequent sessions.

## **Results**

Assessment on bilateral hip internal rotation, left shoulder internal rotation and neck ROM improved after first 2 sessions. Four months after first 2 sessions, third and fourth sessions were done with similar findings but patient reported of improved ROM and reduced symptoms after treatment. On the fifth session, patient's major subjective complaint changed from left hip pain and tightness to left shoulder and neck discomfort. The left hip was not 100% symptom

free, but it did not bother patient anymore. During treatment sessions, patient recalled a fall from a cliff in skiing (the ground was padded by snow) more than 10 years ago which he recalled he landed on left chest area with immediate severe pain that even kept him unable to breathe and move for a while. There was pain inside the same spot of left chest area for many days but as he did not know which type of treatment could help him so he did not seek treatment. Pain eventually went away.

### **Discussion**

This is a case worth a lesson on listening, as the patient's complaints were on the left but the primary lesion, with repeated listening and mobility tests, was found to be on the right. From my understanding, maybe it could be the iliac fascia or the para-renal fascia that transmitted the tension to the left, even though the major tension was on the right. I remember Dr. Jean Pierre mentioned that, the body parts that yield a symptom could be distant from the root cause of the problem. There is much more room for us to understand the connections of the fascia and how does it travel and support the body to make us functional. One thing was missed in this case: listening was not done to understand if there was a lesional chain between primary and secondary lesion and this should be addressed if the patient would come again.

### **References**

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## **Case #7 Digestive problem, constipation, ankle oedema**

### **Abstract**

The intent of this case report is to illustrate the effectiveness of using Visceral Manipulation (VM) and Neural Manipulation (NM) as treatment for a patient with digestive issues after meals, mainly bloating and feeling of fullness on stomach, persistent constipation, unusual weight loss and ankle oedema. Patient tried treatment including traditional Chinese medicine, Craniosacral therapy, without favourable responses. Patient sought for VM in order to help her condition to stay away from medication as offered by conventional western medical treatment.

Key words: Visceral Manipulation, Neural Manipulation, ankle oedema, constipation, digestive congestion

### **Introduction**

For a case with digestive issues including flatulence, severe constipation (can be without defecation for 3 weeks), feeling of fullness, accompanied by unexplained weight loss and ankle oedema, it is imperative to assess liver, stomach, duodenum, pancreas and the related sphincters, to understand how one organ, being dysfunctional, may affect another, and altogether they led to all these symptoms. There are a lot of chemical reactions as well as physiological responses happening when one starts to eat, and vagus nerve plays a role in whether e.g. the oesophagus and stomach would have peristalsis or not, and the timing of the opening of a sphincter, if it is too early, the transit of food would be earlier from one organ to another, then the food could not be digested properly and nutrients could not be absorbed and assimilated fully; if it is too late, then the food might stay overtime in a particular organ, mixed with the digestive juices, resulted in fermentation or the food which manifested as flatulence. An organ cannot be in good shape if it does not have good circulation. It is important to check the vascular system, the left gastric artery, which is the witness of the left vagus nerve. Liver is not to be missed for this case. If the mobility of the liver is not good, the function of liver will be affected and eventually the bile might not be produced optimally and the gall bladder might not be able to work properly to squeeze the bile into duodenum to emulsify fats, which might result in a sense of fullness of stomach after eating a meal with high fat. On the vascular or venous system, for liver, we have to check if the portal system has congestion or not. If congestion is present, we have to also check if there is a connection between the vascular system on sigmoid colon and liver. For if the portal system is not in normal pressure (by checking and listening the pulse of proper hepatic artery), and as portal system has no valves, if the congested condition is serious enough, it would affect the distant part of the portal system that is the sigmoid colon, and with that, it is not surprising that congested venous circulation would result in e.g. ankle oedema. We hope that by utilising listening techniques in VM, we understand the system better, and with the techniques we can release some tension, improve circulation, optimise the movement of the organs and facilitate the system to resume its self-healing capacity.

## **Methods**

Patient was a 54 year old female who was a housewife. She developed digestive issues about 1 year ago, then constipation and ankle oedema for 6 months prior to treatment. There was gradual weight loss despite her rather normal diet (height: 172cm, weight: 85 lbs). Patient had normal appetite but she avoided eating too much to avoid the symptoms and she was worried about the serious constipation problem. Before that, she had consulted a Chinese medical doctor for herbal tea and she took dietary advice from that doctor by eating very oily and fried food for around a year. When she developed digestive issues and constipation, she sought treatment from another Chinese medical doctor, and then she received 30 sessions of cranio-sacral therapy (CST) which was in vain. Hence she came and sought for treatment. Her general health was good with no long term medication required.

### Dates of treatment: September - November 2017, in total 8 session

During initial treatment, General listening (GL) was right side bending, slightly forward bending, below diaphragm. Local listening (LL) with inhibition showed the primary lesion was on liver. Differential listening confirmed it was the parenchyma of liver being the primary lesion. The liver was abnormally hardened. Mobility and motility of liver was severely limited. Extended listening (EL) went to lesser omentum, gastro-hepatic ligament was in tension. As the liver condition was very obvious. The first 3-4 sessions were focused on liver and all its ligamentous system: tests and treatment on mobility, motility, viscoelasticity etc. After the liver getting better mobility and motility, and it was less hardened, treatment was focused on the vascular system of liver. Release of common hepatic artery, proper hepatic artery were done. The liver movement around the vena cava (i.e. internal and external rotation) was sluggish to achieve to optimal state. In the last 2-3 sessions, some work was also done on releasing vena cava. After the liver movement improved in the first few sessions, more treatment was on lesser omentum, lesser curvature of stomach, pyloric sphincter (frozen), and then later on, EL went to sigmoid colon. During treatment sessions, the pre- and post-assessment on right shoulder range of motion (ROM) were done.

Over the course of 8 treatment sessions, GL changed from right side bending and slight forward bend (i.e. liver), to left side bending, slight forward bending (the primary lesion changed to stomach, pylorus). EL remained on sigmoid colon. Treatment on both stomach, and sigmoid colon were done, to release the tension around the both, to improve its motility and mobility. Technique on inferior mesenteric artery was done accompanied by release of sigmoid mesocolon. Cranial physical listening was added in the end of every session, with dural tension was found on upper thoracic level middle. There was also tension on poster-lateral side of right tentorium cerebellum (TC), and such was released.

## **Results**

Assessment on the mobility and motility of liver, stomach and the sphincters were checked every time after treatment. The improvement on the mobility and motility of the organs was slow but gradual and there was no relapse of the condition. The right shoulder ROM on pre- and post- treatment on internal and external rotation improved from 70-90 deg, although

patient did not have complaint on such. Patient reported every time after treatment session, she had normal defecation for 2-3 days. Coming to the end of treatment course, she could maintain defecation once every day or on alternate days, depends on the food she had. She also reported of disappearance of sense of fullness of the stomach and she could eat more as she wished. In early November 2017, i.e. coming to the last few sessions, it was observed that patient's bilateral ankle oedema reduced substantially and it was completely gone in end of November 2017. There was no significant change on patient's weight loss condition - there was no further weight loss but in April 2018, when patient came to have a treatment for maintenance, she reported of weight gain of 10 lbs and she continued to eat normally and she only experienced occasional constipation, which she could improve it by taking more fibre rich food and more water intake.

### **Discussion**

It is shown from this case that VM could help in some systemic disease, e.g. ankle oedema is a symptom of a circulatory problem, which could be due to many different systems, e.g. portal venous system, caval system, heart problem etc. The treatment was, as always, based on listening to treat the structures that are not in normal movement. From the case, it is proved that when the listening is correct and the treatment does not miss the related structure of the involved organ (vascular, fascial), the root cause could be addressed and the symptoms must be improved. Treating the symptoms would be unlikely to bring in long lasting effect.

## **Case #8 Acute neck pain & reduced ROM**

### **Abstract**

The intent of this case report is to understand how an acute neck pain with reduced range of motion (ROM) could be resolved by following listening to locate the system with tension and to release the restricted system in order to relieve the symptoms. The tension area that caused the symptoms may not be on the symptomatic area. Patient came for treatment due to acute neck pain just after waking up. Neck ROM was moderately limited in rotation.

Key words: Visceral Manipulation, Neural Manipulation, neck pain, neck stiffness

### **Introduction**

Symptoms cannot bring us to the root cause of the problem. To have effective and long lasting treatment effect, one must have extensive knowledge on anatomy, physiology and precise listening skills in order to harmonise the dis-equilibrium created by the body after its failure to carry on its compensation in life. Neck pain, neck stiffness with neck muscles spasm just after waking up is not uncommon, but the same symptom can be attributed from different origins. This case is aimed at proving the close relationship of visceral movement and function on an apparently musculo-skeletal condition. It is not very useful to hypothesize the reasons of neck pain sometimes even if it is based on anatomy knowledge. The interesting part of this case was that we wanted to understand when the patient's restricted area, which was primarily on the fascial layer covering the stomach, and the gastro-splenic ligament, which connected the greater curvature of stomach to the hilum part of the spleen, was being released, how it would affect the acute neck pain and other neck symptoms. Furthermore, if there is an effect on the symptoms by releasing the visceral and fascial components that was found on the body through listening skills from visceral manipulation (VM), we hope to postulate a relationship of neck pain and the restricted body part through a true understanding of the related anatomy on visceral, fascial and neural connection. Listening and treatment techniques from VM were employed.

### **Methods**

Patient was a 64 year old female, a housewife with main activities were doing chore duties at home. She developed acute neck pain which also radiated to left upper trapezius after waking up in one morning. The pain was very irritable and the neck rotation and side bending were vastly reduced. The neck pain was affected even in gentle trunk rotation, or when patient was in deep respiration. General health was good with no significant injuries that could be recalled. Patient was anaemic due to iron deficiency from medical diagnosis. She reported of history of tuberculosis when she was 20 years old and it was on her left side of lungs. She received 9 months medication to suppress the condition.

### **Date of treatment: 2 December 2017**

General listening (GL) was an obvious and big left side bending, left rotation to slightly posterior, below diaphragm. Local listening (LL) with inhibition and differential listening illustrated the primary lesion was on gastro-splenic ligament, with Extended Listening (EL) going superior, lateral, with a sense of gliding. Cranial physical listening at vertex was to the left side, postero-laterally, superficial with sliding feeling going down along cranial bones down

to neck region. Assessment on neck range of motion (ROM) showed severe limitation in bilateral rotation with left side more limited, with right side bending was moderately limited. Assessment on diaphragm through assessing the rib 6 and rib 7 showed there was tension on left side of diaphragm. Mobility and motility tests with listening techniques on stomach, spleen and pancreas were done, these three organs had limited motility (in expir phases) and mobility. There was a definite tensional relationship of stomach and spleen, and that they both had the same limitation in directions in mobility and motility. Treatment began by working on the gastro-splenic ligament, using direct technique to free up its tension. Then the stomach was treated by freeing up the tension on the greater curvature with the greater omentum and the spleen. The spleen was then treated to optimise its mobility in all direction, and tension was also found on phrenico-splenic ligament, which was then released. Finally the tail of pancreas in relation with the spleen was treated as tension was found there. Listening to Rectus Capitus Posterior Minor (RCM) showed limitation on left dural tube at lower cervical level. We tried to take left arm as long lever to release the dural tube tension but it was not completely released. Locally the left RCM and the left oblique capitious superior and inferior were in tension. Suboccipital nerve on left side C2 level was treated and tension on left RCM, the oblique muscles was gone. Cranial physical listening at vertex was to left side lateral, with confirmation by assessing the temporal bones, the jugular foramen on left was impacted. Opening of this foramen was done. Finally, motility of stomach with spleen and motility of pancreas were checked and normalised through induction. Post-treatment general listening was to the left pleura.

## **Results**

After treatment, patient immediately felt relaxed on the left neck region, she could have deep respiration with no pain, but the neck ROM in bilateral rotation and side bending was still limited. Next day after the treatment, patient called back and she found the neck pain was gone and the neck could move freely.

## **Discussion**

The contracted muscles around the neck, eg. Upper trapezius, sternocleidomastoid (SCM), could be linked with accessory nerve (CN XI) while the scalene muscles are innervated by the cervical and brachial plexuses (1). Bordoni & Zanier advocated that (1) “it is worth emphasizing that a brachial disorder can provoke phrenic and diaphragmatic disorders”. It is not surprising to see that a tension on the gastro-splenic ligament could affect the diaphragm, and the diaphragm has connection with phrenic nerve, and phrenic nerve is derived from C3-5 nerve roots, hence a tension on the gastro-splenic ligament could lead to symptoms on the neck. Even the muscles around the neck are being tight, by just working on the muscles themselves would not yield long lasting effect. If listening leads us to the neural structure, we should work on the neural structure first and see how it affects the muscles around. The case would require further follow-up to assess and treat the left lung and pleura to clear the tension there.

## **References**

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## **Case #9 Pregnant patient with back pain, coccygeal pain, foetus's head had not turned down at week 32**

### **Abstract**

The intent of this case report is to use listening techniques from visceral manipulation (VM) to try to help relieving a pregnant patient's back and coccygeal pain. Patient who was pregnant for 34 weeks came for treatment due to unrelieved coccygeal pain for a few weeks. She also mentioned that after ultrasound check-up, the foetus's head had not turned downward at week 32 and she was recommended to have caesarean section if the baby had not turned downward at week 36.

Key words: Visceral Manipulation, pregnancy, back pain, coccygeal pain, breech position

### **Introduction**

During pregnancy, there are a lot of changes in the body: the hormone relaxin is released from the ovary and placenta to help relaxing the ligaments around the pelvis in preparation of delivery. With the loosening of the ligaments around the pelvis, while the intra-abdominal and pelvic pressure keeps on increasing due to the growth of the foetus, it is easy to develop disharmony on the whole body system including visceral, fascial osteo-articular systems. When the body loses the ability to compensate the disequilibrium, symptoms eg. pain would result. The round ligaments, uterosacral ligaments, and broad ligaments have to be free for the uterus to expand properly in order to adapt to the growth of the foetus. Then, sacro-spinous and sacro-tuberous ligaments should be checked to have no abnormal tension for the pelvis to keep in a stable, optimal and symptom free position. Pelvic floor muscles, endo-pelvic fascia, and obturator membranes and its related nerves, have to be restriction free as well. Then the lumbar spine, the lumbar plexus and sacral plexus should also considered in assessment. As the foetus keeps growing and expanding, the unequal elasticity of the ligaments around the pelvis could create asymmetrical pressure on the urogenital organs which may leads to various symptoms. The breech position of the baby could also be due to the imbalance of the fascia and ligaments around the uterus, which limited the uterus to expand sufficiently for the foetus to move around. By utilising the listening skills and treatment techniques from VM, we want to understand if the structures involved, after being released, would have any effect on the symptoms from the mother, and also would it affect the breech position of the foetus.

### **Methods**

Patient was a 36 year old pregnant lady, who worked sedentarily. It was her second pregnancy. She developed back pain and coccygeal pain a few weeks prior to treatment at week 34 (so pain developed at around week 28-30). The pain could not be relieved in any position and it affected her sleep. There was a pulling sensation on her coccyx. She was also worried about the fact that the foetus's head had not turned downward to be ready for delivery. Caesarean section was suggested if the foetus's head did not turn downward towards the cervix at week 36. Patient's general health was good with no known medical history.

Date of treatment: 28 April 2016 (Patient was at week 34)

General listening (GL) was left side bending, long, with GL done in sitting, it was confirmed it was not from lower limbs, but should be on the pelvic level very close to endo-pelvic fascia. Local listening (LL) with inhibition and differential listening confirmed the primary lesion should be on left round ligament, with extended listening (EL) on left cardinal (or broad ligament), left uterosacral ligament. LL on sacro-coccygeal spine when patient was in side lying position was on left lateral sacro-coccygeal ligament, superficial and deep posterior sacro-coccygeal ligaments. In general, listening to the uterus was like a big fascial pull towards the left inferior side of the uterus. Treatment started from releasing the round ligament on the superficial inguinal canal and major labia level, then the left uterosacral ligament with one hand anterior one hand posterior to feel the connection in between and to do stacking and induction. Afterwards, patient was in side lying position with knees bent, through listening and induction it was attempted to release the left lateral sacro-coccygeal ligament, the superficial and deep posterior sacro-coccygeal ligaments. Afterwards, very gently and cautiously, listening on the uterus was done, it was intended to harmonise the uterus to try to eliminate the left lateral inferior pull of the uterus. Post-treatment GL was silent.

### **Results**

After treatment, patient felt the lumbar area was relaxed. Two days after treatment, patient reported of disappearance of the back pain and the coccygeal pulling pain. At week 36, patient was arranged to have ultrasound check up again and she was found the foetus's head had turned downward and she was good to have natural delivery. The natural delivery was very smooth and it took less than 2 hours from labour to delivery.

### **Discussion**

The primary intention of the treatment was to relieve the patient's back and coccygeal pain, which was resolved after treatment. The surprising thing was, the foetus's position, after the treatment (which the tension on uterus was released), changed and the head went downwards towards the cervix, and the labour and delivery was smooth and it was not very painful. We cannot be certain if the change of foetus's position is due to the treatment or not, suffice to say that the treatment did release the abnormal tension on the uterus and the pelvic area.

## **Case #10 Left upper & mid back pain**

### **Abstract**

The intent of this case report is to illustrate the effectiveness of using listening skills from Visceral Manipulation (VM) to locate the tensional areas of the body, together with the treatment techniques of VM and Neural Manipulation (NM) for a patient with chronic left upper and mid back pain. The pain occurred after she had given birth to her second child, that is around 1 year prior to the treatment.

Key words: Visceral Manipulation, Neural Manipulation, upper back pain, mid back pain, thoracic pain, pericardium

### **Introduction**

Symptoms can rarely tell anything about the root cause of the problem. The system has so many layers and structures, to blame the pain coming from the osteo-articular structure misses a big portion of the whole system. It is hoped that through this case, one can understand more that an apparently similar kind of symptom from the similar part of the body can be attributed from totally different structures. Left upper back pain could be due to stomach, esophagus, but this case, the root cause that we found through listening and mobility test was from the pericardium and its ligaments. The mediastinal pleura was also involved as it is also connected with the parietal pericardial fascia. We want to understand that after confirming the primary lesion through listening skills and mobility tests, and with VM techniques to release the restricted visceral, fascial and neural components, whether the symptoms would have a favourable response or not.

### **Method**

Patient was a female aged 32, who had two children aged 1 & 3. The first newborn was delivered by cesarean section. She complained of left upper and mid back pain soon after giving birth (natural deliver) to her second child. Patient was a housewife. Her general health was good with no known medical history.

### **Date of Treatment: 1 July 2018**

General listening (GL) was slight left side bending, short, above diaphragm. Local listening (LL) showed two areas that could not cancel out each other, they were right antero-inferior parietal peritoneum, and left pleura /mediastinal pleura. Through listening it was found that there was line of tension between the two, which could be fascia transversalis and endothoracic fascia. Extended listening (EL) from the right antero-inferior parietal peritoneum was to the superior to the left, superficial, which was like the parietal peritoneum. The EL from left mediastinal pleura was inferior towards the subcostal level, and then it went deep towards the body, by inhibition it should be phrenico-pericardial ligament. Bilateral ovaries were checked on motility with the right ovary was overactive while the left one was sluggish. Mobility and motility on stomach, spleen, and heart were limited. The axis of motility of the heart was twisted. Osteo-articular assessment showed right sacroiliac joint stiffness, while bilateral hip internal rotation (IR) was moderately limited. Left shoulder demonstrated limited internal and external rotation (ER). Cranial physical listening on vertex showed listening on dural membrane layer, to the left, very lateral. Manual thermal evaluation (MTE) and cranial

emotional listening were also done but this would be discussed in details in case report for VM5 & 6.

Treatment began on release of right inferior parietal peritoneum, followed by synchronising right ovary motility with the left. Then the left mediastinal pleura was being stacked in order to release the restriction, release of tension on phrenico-pericardial ligament, followed by release of vertebro-pericardial ligament (more restricted on the left). It was found tightness on gastro-splenic ligament and treatment was done. Due to the close relationship of diaphragm with the phrenic-pericardial ligament, diaphragm was checked and was released through stabilising L1 spinous process while mobilising rib 10 on left, then listening with direct technique induction to release the left side of diaphragm. By locating the direction of barrier to build up the stacking, then induction, to restore the mobility and motility of both stomach and spleen were done. Afterwards, technique of neural manipulation (NM) with opening of left jugular foramen was done, followed by release of dural membrane with left upper limb active movement as a long level. Finally, heart motility was checked and optimised through induction in indirect approach.

### **Results**

Post treatment, left shoulder IR and ER were full, bilateral hip IR and ER were also full. Post treatment GL had no listening. Subjectively, patient reported that she could stand up with chest lifted up easily and she was aware of the improved ROM of left shoulder. Two days after treatment, patient reported back that the left mid and upper back pain subsided.

### **Discussion**

Treating the fascial and visceral structure alone was proved again effective in relieving symptoms that appeared to be on osteo-articular or musculoskeletal level. Without working on the shoulder complex, after releasing left pleura, left phrenic-pericardial ligament and gastro splenic ligament, the left shoulder ROM was full. The innervation of the treated structures and the shoulder complex had fascial connection and also neural connection that made the visceral ligaments having an effect on the ROM of shoulder complex. The clinical experience of using VM on patients reassured us that we have to see the patient as a totality, considering every system even just for one symptom.