

Face & Body Numbness, Vertigo, Nausea, Head Pressure and CranioSacral Therapy

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Abstract

Objective: To describe the care of a patient with left-sided face and body numbness and vertigo, nausea and pressure in the left side of his head.

Clinical Features: A 39-year-old male was provided CranioSacral Therapy for the complaints of left facial and left-sided body numbness. He was also experiencing dizziness and nausea, which started at approximately the same time. He was admitted to the ER and underwent a CT of the head and neck, an EKG, blood work and chest X-rays. No abnormalities were detected and the patient was told that he might be experiencing a Migraine.

Intervention and Outcome: The patient was cared for with CranioSacral Therapy to relax the Dura and soft tissue structures surrounding thoracic diaphragm, occipital diaphragm and the soft tissue structures and the cranial bones around the internal acoustic meatus. The patient's response to care was positive and after the first treatment he reported the pressure in his head to be reduced by at least half. The next day the patient reported that he felt no numbness, no dizziness and no pressure in the head.

Conclusion: There are indications that individuals suffering from one-sided face and body numbness, along with vertigo, nausea and pressure in the head, as presented in this case, may benefit from CranioSacral Therapy.

Introduction

A 39-year-old male presented with a sudden onset of facial and left-sided body numbness. He also had dizziness and nausea. He was taken to the ER and had several tests performed, including a CT scan of the head and neck, EKG, bloodwork and chest X-rays. No abnormalities were detected and the patient was told that he might be experiencing a Migraine. The patient had no history of migraines. He was offered pain medication and instructed by the medical doctor to go home and make an appointment to see his primary care physician during the next week.

The following day the patient's symptoms intensified and two days after the initial onset of symptoms, the patient developed pressure in the left side of the head, which caused him to go to urgent care. At urgent care an EKG was run again, with no abnormalities found. The patient was diagnosed with a "pulled muscle" in his chest, even though there was no mechanism of injury and the patient stated that he didn't have pain in that region until after the doctor had palpated his ribcage forcefully.

After leaving urgent care, the patient came into our office. The patient reported feeling dizziness, nausea, pressure in the head on the left and numbness over the left face, left arm, and left leg. The patient mentioned that the night before his symptoms started, he was using a Q-tip in his left ear and his wife accidentally hit it with her elbow, which caused the Q-tip to hit the patient's eardrum.

The patient had been under intermittent chiropractic care for two weeks for the relief of chronic low back pain. The patient had daily discomfort in the low back, which occasionally included left sciatica. Additionally, the patient complained of muscle spasms and a "locking" feeling in the mid-thoracic spine and shoulders. The patient had received chiropractic care in the past from several different chiropractors, but had not been adjusted during the past year. During the history, the patient revealed that he smokes cigarettes daily.

Examination

The tympanic membrane was visualized using an otoscope and found to be slightly reddened along the anterior portion. No ruptures, infections, nor fluid levels were visualized. No hearing loss was reported.

Myotomal testing revealed decreased finger flexion (4/5), elbow flexion and extension (4/5) on the left side. Dermatomal testing revealed decreased pinwheel and light touch sensation over the left cheek and chin, but not over the forehead or the extremities. Deep tendon reflex testing was unremarkable in the upper extremities and was decreased on the left in ankle flexion (1/4). Pupils were bilaterally symmetrical and reactive. Facial muscle strength was bilaterally equal and symmetrical.

The craniosacral rhythm in the chest cavity and neck was greatly restricted. The symmetry, quality, amplitude and rate were all unbalanced. The left portion of his rib cage and the thoracic diaphragm was restricted along with his cervical spine, lacking the ability to move into flexion as well as extension. His respiratory diaphragm also felt restricted under the left floating ribs. The Cranial bones were out of symmetry, especially the temporal bone on the left hand side, which lacked flexion and extension. His Occiput, partials, sphenoid and maxilla on the left all lacked normal movement and were generally unbalanced.

Management plan

Treatment began by releasing the upper thoracic diaphragm. The fascia1 strain pattern was followed as it moved left to right anterior and lacked almost all motion in the posterior. A deep therapeutic pulse could be felt just posterior to the left first and second ribs. A mild warming sensation was also felt just anterior and inferior to the SEM muscle. After the thoracic diaphragm was released, which took about three minutes, the strain pattern was followed to the lower left portion of the respiratory diaphragm and the left floating ribs. Once again a therapeutic pulse was felt at the level of T8-T9 in the area of the posterior hand. The patient had a large sigh, after which the craniosacral rhythm in the respiratory diaphragm was balanced.

The hyoid bone and its surrounding soft tissue structures were greatly restricted primarily in the digastric muscles, which were relaxed with gentle pressure. The suboccipital musculature reacted slowly to decompression, which was where the majority of the time in first session was spent.

Once the Occ- CI were relaxed and moving more freely, the temporals became the primary objective. The temporal bones were moving completely asymmetrically. The temporal bones were first balanced in flexion an extension, then internal and external rotation. Finally, the temporal bones were decompressed from the rest of the cranial bones. The occipital suture of the parietal bones was relaxed and then opened, followed by the temporal suture of the parietal bones. Each suture was initially addressed individually and then together as a group. The session was concluded with the CV 4.

The second session started with review of the respiratory and thoracic diaphragms, then quickly moved on to the hyoid and the occipital regions. The temporal bones were no longer balanced, however, they were moving much more freely. Cranial work was performed by first decompressing the frontal bone, the parietal bones, the occipital region, then balancing the temporal bones. Decompression of the sphenoid was preformed next which brought into balance the remainder of the cranial bones.

Work in the mouth began by releasing the Zygoma bilaterally then the maxilla bilaterally. All mouth structures were balanced following Upledger's 10 step protocol. Decompression of the temporal and maxilla on the left was done until movement palpated balanced in regards to SQAR. The session was concluded with the CV 4.

Discussion

The true ideology of all the chief complaints was never completely explained. The intracranial work around the external auditory meatus where the facial and the vestibulocochlear nerves share much of the same connective tissue, corresponds directly with the facial numbness, the dizziness and vertigo. However, the complete recovery of the left-sided body numbness that was more transient would not be directly explained with corresponding neurology. Because of the severity of the symptoms, this case was considered a medical emergency. In this case the tests that he underwent: the CT of the head and neck, the EKG, blood work and chest X-rays revealed nothing of great significance. The patient was released with no treatment given and the explanation of a Migraine headache.

The Role of Craniosacral Therapy

Craniosacral Therapy, in this case, provided the necessary movement to the specific areas restricted in the upper chest, neck and intracranial areas around the temporal bone. The patient had two Craniosacral Therapy sessions that lasted about 25 minutes each. The cost of the therapy totaled \$130. The patient was very pleased with the outcome and said that he felt that we did so much more for him than the exams and treatment of the traditional medical system. The cost of the emergency room and urgent care visits was unknown because the patient paid an insurance co-pay for each visit and procedure. The patient was thrilled with Craniosacral Therapy and stated that it was less invasive and more effective than what he had tried before.

Conclusion

Successful case management of a 39 year old male with complaints of left facial and left-sided body numbness, dizziness and nausea reported 100% resolution of all symptoms after two sessions of Craniosacral Therapy. Craniosacral care was provided based on the restrictions in the diaphragms and the fascia1 strain patterns within the body. Prospective research into the efficacy of this approach to health care is encouraged. The possible role of craniosacral evaluation and treatment of an individual with facial and body numbness along with dizziness and nausea should to be explored.