Low Back Pain / Car Accident and CranioSacral Therapy

By: Lisa Desrochers

Patient history: Debbie is a 49-year-old female who was referred to physical therapy following involvement in an MVA in which a large truck backed into the passenger side of her car. She was wearing her seat belt and traveling approximately 20 MPH at the time of the collision. She experienced immediate low back and neck pain and saw her Chiropractor within two hours of the accident. She was not seen by an MD or emergency room. She was referred to physical therapy via the Chiropractor one week later with a diagnosis of cervical and lumbar sprain/strain. By her report, cervical and lumbar X-ray performed at her Chiropractor's office showed subluxation and EMG demonstrated muscle spasm. No other studies were performed.

Past Medical History: Her past medical history was significant for involvement in a serious MVA fourteen years earlier in which she suffered mandibular and maxillary fractures and lost all of her front teeth. In this accident she also sustained neck and back injury. Since that time she had suffered TMT dysfunction for which she was followed by an Orthodontist. She experienced frequent headache and occasional lingering neck and low back pain and tightness. She also suffered from interstitial cystitis, for which she had been under the care of an Urologist, and had undergone treatment via various pharmaceuticals over the previous 14 years. Her bladder symptoms included severe burning and urinary urgency with inability to void completely. She reported that many days she was unable to leave her house due to these symptoms. She stated these symptoms were mild prior to the first MVA but progressively worsened over the two years following the original MVA. They were aggravated further by the current MVA.

Medication: Her medications included Naprosyn, Darvocet, Tylenol and Anaprox.

Subjective Symptoms: She described her current pain as constant aching, pulling and tightness in her left low back with sitting, standing, driving and bending. She related experiencing occasional numbness of her right great toe. She reported tightness in her neck, more on the left than the right, and "fullness" in her right ear. She stated she often felt disoriented and could not think clearly. She also complained of daily, severe headaches.

Social History: She was not employed outside the home. She had a teenage son and a husband who worked full time. She stated she had difficulty driving and was unable to do laundry or vacuum. She could lift only very light (1-2 pound) objects.

Relevant Initial evaluation findings:
Observation: Debbie is mildly obese. She moved in transfers and gait very slowly and deliberately. Moderate facial asymmetry was noted with a superior left eye, prominent right zygoma and superior right mandibular angle.

CranioSacral: Arcing revealed several large energy cysts. The most notable is within the cranium at or near the left maxillary palatine suture. Others were posterior to the orbit of the left eye, in the cervical region left and just posterior to the trachea, just posterior to the most inferior aspect of the sternum and in the right superomedial thigh. The CSR was generally sluggish with a ratchety quality in the cranium. Amplitude was decreased predominantly at the left thorax shoulder and cranium. The cranial vault and facial bones were all found to be limited in mobility. Specifically, the frontal bone had numerous sutural restrictions along the coronal suture, the left temporal bone was jammed in extension and would not flex, the left parietal seemed impacted onto the temporal bone and a classic

extension lesion was noted at the sphenobasilar junction. Additionally, the entire maxillary complex was compressed onto the sphenoid and demonstrated a right sheer, the vomer demonstrated a right torsion lesion and the left zygoma was impacted into the maxilla and frontal bone with resultant sutural restrictions. All of these boney sutural restrictions made evaluation of the underlying intracranial membrane system difficult, though there was a distinct sense that there were sever restrictions. Dural tube traction revealed restrictions at the C1, C2, C3 and C4 levels all on the left, C6 on the right, centrally at T9 and T10, L3 on the right and L5 on the left. Of these, only the C1, C2, TI0 and L5 roots were noted to be facilitated.

Posture/alignment: Debbie stood with an elevated right shoulder. a left cervical shift with right cervical rotation, a forward head, rounded shoulders (right greater than left), an increased lumbar lordosis which extended into the low thoracic region, a flattened mid thoracic kyphosis, an anterior sheer of the C7 and T1 segments, elevated right iliac crest and PSIS, left pelvic obliquity, level ASIS and level greater trochanters.

ROM:
TRUNK ROM
Flexion 70%
Extension 60%
Side Bend - Right 80% - Left 90%
Rotation - Right 80% - Left 90%
NECK ROM
Flexion 70%
Extension 70%
Side Bend - Right 50% - Left 80%
Rotation - Right 80% - Left 90%

Palpation: Protective spasm generally over paracervical musculature and the posterior and lateral lumbar musculature. Increased tissue density noted over the right Gluteus Medius and Piriformis. Point tenderness was reported in all these areas.

Passive Segmental Mobility: C6, 7 and TI segments were locked in flexion. Grade II restriction to right side down glide of the C5-6 segment and the right L4-5 and L5-S1 segments.

TMJ: Left mandibular deviation noted on opening.

Sacroiliac: S2 moves with the right PSIS with march testing. Right sacroiliac joint locked with the right innominate in anterior rotation.

Neurolorical Findings: Debbie denied any radicular signs or symptoms at the time of the evaluation. All UE and LE myotomes, dermatomes and DTR were intact and symmetrical.

Assessment/clinical diagnosis: The trauma of the recent MVA imposed over the existing dysfunction from the previous MVA caused wide spread neck and hack pain. My initial assessment was that the existing pelvic dysfunction amplified the lumbosacral pain. It was apparent that the pelvic dysfunction pre-dated the recent MVA due to the longstanding nature of the surrounding tissue accommodation and fibrotic tissue changes. The cervical in was similar to the pain she had experienced since the original MVA, only amplified. This, also, was likely due to trauma superimposed on existing dysfunction of the TMJ and cervical spine.

Course of treatment: Debbie was initially treated two times a week. Initially, the sessions focused on releasing sutural restriction of the cranial and facial bones utilizing direction of energy in combination with structural releases. As these sutural restriction were gradually released over the first five sessions the severity of the membranous restrictions became apparent. The anterior portion of the faux cerebri and left tentorium were nearly immobile with a thick, leathery feel to the membrane. At that time we began to work with the energy cyst in the left palatine region. Initially, only a partial release of this cyst was achieved. This was primarily because release of the energy cyst triggered the SomatoEmotional release process and significant resistance was encountered. Over the next three sessions the SER process brought us to several different stages in her life. Though she seemed to want to talk most about the MVA 14 years earlier, this event was not significant with regard to the cranial rhythm. During this process she skipped in and out of relatively minor falls and injuries at different period in her life, again without a significance detector. Finally, during the eighth treatment session she went back to age six and at this age, when she visualized her mother, there was a significant stop of the CSR. She quickly talked her way back to the MVA, and each time we tried to go back to six years old she would do the same. When I asked there might be anyone who could come back with us to six years old to help her and make her feel safe she responded "Trina". She looked a little surprised, smiled and said she had forgotten about Trina. She said Trina was her imaginary friend when she was little. With Trina's help over the next five sessions she related several incidents of abuse by her mother from ages four through six which culminated in her mother swinging the iron across the left side of her face, breaking her cheek and jaw and resulting in her removal from her mother's home. In the end, as the energy cysts in the left palatine area and left orbit released simultaneously, she expressed the loneliness of being taken away from her mother. At the time she was told by her paternal grandparents that she was going to be so much happier and better-off without her mother that she never felt allowed grieving losing her. Following this session she experienced significant reduction in her headaches, neck and back pain. She was most surprised to also experience a 75% reduction in the urinary symptoms. The next two sessions we worked on integration and "fine tuning" primarily with some muscle energy techniques for the cervical limitation and the pelvic malalignment as well as vector alignment and meridian balancing.

Three months after discharge she contacted me to say that she felt better than she would ever remember feeling. She said she felt twenty years younger and that friends had commented that she actually looked several years younger. Though she continued to experience occasional twinges in her low back, she stated that the neck pain and fullness in the right ear were nearly gone and that she had not experienced a headache since the last treatment. She reported being able to do things around the house that she had not done in years.