

Shoulder Pain and CranioSacral Therapy

By: Fred Stahlman

A. PERSONAL:

This patient is a 44 year old Caucasian male.

B. HISTORY:

1. Symptoms: This patient initially presented with constant left scapular and shoulder pain with mild radiation into the left upper extremity. The pain intensity was classified as a 7/10 on a 10-point pain scale. The symptoms were aggravated by increased physical and work related stress (patient is a pulmonologist and his symptoms are exacerbated with intubation techniques. His symptoms also were aggravated by bike riding and falling asleep in his lazyboy recliner. Because of his pain he is also noticing some mild disuse atrophy.

2. Pertinent Medical History: Patient #2's symptoms began approximately one year ago when he was sitting on the floor leaning against a stereo speaker with his daughter leaning on him. After sitting this way for several hours, he began to notice some discomfort in the left scapular and shoulder girdle complex and a mild irritation into the left arm. Shortly thereafter, he began to experience a C-7 distribution pain which was primarily sensory with some minor motor functional loss as well. His symptoms ranged from intermittent to constant over a two month period and it seemed to resolve with a traditional physical therapy regimen of ultrasound, muscle relaxants, moist heat, stretching and strengthening exercises. He was also taking Clonipen for nerve pain His symptoms seemed to resolve within two months of their onset and the initiation of a physical therapy program.

1. Findings: The initial objective findings were as follows: active range motion of the left shoulder was within normal limits and strength was within 5/5 (within normal limits). Sensory testing also revealed no neurological deficit. Reflexes were intact as was light touch, deep touch and proprioception. Cervical spine active range of motion revealed limitations as follows: Forward bend was essentially within normal limits as was extension. Rotation left and right were 80% expected range with end range tension but no pain, side bend left was 75% of the expected range within range strain and side bend right was 70% expected range with sharp pain. Palpatory findings revealed high tone and guarding of the scapular elevators and left cervical paraspinals especially the levator, the trapezius and scalenes. There was pelvic asymmetry with the right ileum demonstrating an anterior rotation pattern with the right leg being longer than the left. There was adverse mechanical tension throughout all of the diaphragms, especially the thoracic inlet, and a marked occipital cranial base compression especially on the left (2/5, with 5 being within normal limits).

2. Tools Used: The treatment approach consisted primarily of CranioSacral therapy techniques to open the thoracic inlet, the left shoulder and shoulder girdle complex and the occipital cranial base. Direction of energy, regional tissue release, fascial mobilization and rib and clavicular recoil techniques were used. In addition, the patient was encouraged to focus his breath as well as use visualization and guided imagery to open the cervical thoracic complex.

3. Objective Results: Cervical range of motion following the treatment regimen was within normal limits without pain. Dural tube mobility was within normal limits and there was reduced fascial tension throughout the cervical thoracic and cervical scapular complex. Pain levels was 0 and functional use was within normal limits without pain.

4. Subjective Results: Patient related a sense of freedom and mobility that had not been present for over a year with a no sense of adverse mechanical tissue tension when he would move his neck through full range of motion and left shoulder through full range of motion.

5. Average Length of Sessions: This patient received one physical therapy evaluation and treatment lasting approximately one hour and 15 minutes which included the evaluation and full treatment session. No further treatments were necessary as the client was now asymptomatic.