# Barral Institute Case Study

# Visceral Manipulation – Atrial Fibrillation & Breathlessness


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Last treatment session: March 2016

Presenting Symptoms

This 72 year old female presented with chest symptoms that she attributed to her atrial fibrillation (AF). She was breathless on exertion; this had started in 2013/14 when she went into AF after having a severe chest infection. Recently she also had noticed that her voice had become hoarse and described a recent flare up of oesophageal reflux, intermittent mid sternal pain, neck pain and an irritable cough. Her past medical history included two cardioversions for AF, gastro-esophageal reflux (large sliding hiatus hernia), controlled hypertension, IBS and bilateral knee pain. Investigations for the breathlessness included a chest x-ray and lung function tests which were normal. She had blood tests which demonstrated slight changes in thyroid function (subclinical) which were thought to be due to the drug used to manage her AF (Amiroderone). Endoscopy results demonstrated scarring in the larynx from acid reflux.

Evaluation and Treatment

General listening (GL) was left, anterior and above the diaphragm. GL from the upper limbs was to the same location in the left upper sternum. There were two local listenings close in proximity, one to the manubrium which had an extended listening to the thyroid gland and the other to the pericardium, specifically the left superior pericardial ligament, inhibition indicated that the pericardial listening was dominant. Sternum decompression testing was positive at 40% depth in the upper mediastinum. Motility of the heart demonstrated some minor limitation of inspire in an inferior direction. There was increased thickening of the thyroid tissue on the right, but no nodules suggesting some localised thyroid congestion.

Initial treatment was induction of the superior sterno pericardial ligament. Further GL was to the throat and LL to the left vagus nerve in the visceral sheath of the neck. Treatment was to the superior laryngeal nerve (branch of the vagus nerve) in the thyrohyoid space.

In consecutive sessions GL was posterior, just below the diaphragm and slightly to the right of midline. LL was to the inferior vena cava (superior/lateral aspect) just posterior to the portal vein at the transverse groove of the liver, with an extended listening to the aorta. There was some restriction of active neck rotation particularly to the right (50 degrees) and also thoracic intervertebral motion was restricted at T8/9. Treatment involved induction of the inferior vena cava in association with the aorta. In addition T8 and T9 costovertebral joints were treated in side lying to affect the sympathetic chain at these levels. Further GL was to the portal vein and there was also an emotional listening to the pericardium. Liver motility had only 20% inspir and expir. Treatment included a specific technique for the portal vein, viscoelastic release of the liver, posterior roll of the liver to treat the posterior coronary ligament and the portal vein as it runs down the bare area; also the right and left triangular ligaments of the liver were released. The right (and left) phrenic nerves were treated in association with C4. Induction of the liver into the direction of most ease (expir) was

used and motility of the liver improved to 70% in both directions. An emotional treatment associated with the pericardium (non verbal dialogue) was used and induced an emotional release response.

Results

The client had 3 sessions, approximately a month apart, her cervical and thoracic range of motion significantly improved which she felt had significantly improved her general mobility, she was also noticeably much less breathless on exertion and had started being able to exercise regularly again.