

Barral Institute Case Study

Visceral Manipulation – Acid Reflux Symptoms

Anna Cawthorne, PT, CVTP

Last treatment session: 16th June 2016

Presenting Symptoms

This 48 year old female had a 2-3 year history of acid reflux symptoms following a period of long term stress. She was describing a constant sensation of a lump in her throat, occasional hoarseness of her voice and an intermittent sore throat. A previous endoscopy had showed a small sliding hiatus hernia. She had tried omeprazole without effect and had also made some dietary changes. Other significant past medical history included mild IBS.

Initial Examination

General listening (GL) was to the left, anterior and just above the diaphragm. Local listening (LL) was to the cardiac sphincter, there was an extended listening to the vagus nerve in the lesser curve of the stomach. There was also an associated listening to the left gastric artery. Passive intervertebral motion of T5 was restricted. There was a positive left adson's wright test with diminished radial pulse and restricted abduction and lateral rotation of the left shoulder, the left radial pulse improved with inhibition of the stomach. Mobility of the phrenico-oesophageal ligament was restricted in a medial direction. Motility of the stomach in expir was restricted to 70 percent and expir was not restricted.

Treatment

Initial treatment was to the cardiac sphincter to facilitate clockwise rotation, other sphincters were functional. The phrenico- oesophageal ligament was treated and released in the direction of ease and progressed to a direction of tension technique. Longitudinal release of the gastro-oesophageal junction was treated in sitting and the gastro-oesophageal junction was also balanced with T10/11. The vagus nerve was released at the lesser curve of the stomach. Following this the left gastric artery was treated and also a double listening/release was done between the celiac trunk and the left gastric artery. Motility induction of the stomach and also the oesophagus were balanced together facilitating the direction of ease (expir) of the stomach. The celiac plexus was slightly erratic and was balanced with the left frontal zone. In the 2nd session GL was to the left side of the throat and LL was to the proximal oesophagus at C6 on the left. Extended listening was to the vagus nerve on the left on the anterior/lateral wall of the oesophagus, it had a slight 'buzzy sensation'. The left vagus nerve in the carotid sheath was treated with induction until the abnormal sensation had diminished and expansion and retraction phases were smoother and more balanced, also a double listening between the left vagus nerve in the carotid sheath and the proximal oesophagus was completed. The right vagus nerve was also treated in the carotid sheath to ensure there were no restrictions along the course of the

vagus nerve in this region. The cardiac sphincter was dysfunctional and was treated with induction to achieve clockwise rotation. The other sphincters were checked and were all functional. The oesophagus was treated with motility induction and expir and inspir were 80-90%; stomach motility (inspir and expir) also improved to >85%-90%.

Results

The patient attended 2 sessions, 6 weeks apart. She felt the treatment has improved her symptoms as the intensity of the symptoms had settled. She was focusing on relaxation techniques to help manage her stress levels and improve her symptoms further as she felt this was a significant factor.