

Barral Institute Case Study

Visceral Manipulation – Epigastric Pain

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Last treatment session: 16th May 2017

Presenting Symptoms

This 44 year old male presented with an acute onset of significant epigastric pain. He reported intermittent pain in the upper abdomen over the previous 1-2 days but symptoms had recently become acute immediately after eating a large meal. He described the pain as a significant 'boring' pain in the upper abdomen, he was also experiencing nausea and some associated mid thoracic pain; the symptoms felt easier when he was lying down. He was also reporting left sciatic pain that had started just prior to the onset of the upper abdominal symptoms. He did report a history of intermittent bloating and indigestion over the last 6 months that usually occurred after eating large meals.

His past medical history included a right total hip replacement for avascular necrosis 3 years ago and also a peri-anal abscess several years ago. There were significant lifestyle factors including smoking and a tendency to binge drink, he also had a history of anxiety.

Initial Evaluation

General listening (GL) was anterior, left sided and just below the diaphragm. Local listening was to the internal surface of the anterior stomach wall, close to the lesser curvature of the stomach. Extended listening was to the lesser omentum between the left lobe of the liver and the stomach. Transverse mobility of the stomach was reasonable however vertical mobility of the stomach was restricted on the medial aspect of the body of the stomach. Motility of the stomach was restricted to approximately 40-45 % in both inspir and expir, with inspir being slightly more limited particularly in its lateral and superior aspects.

Treatment

Treatment involved releasing restrictions of the lesser omentum between the left lobe of the liver and the lesser curvature of the stomach, affecting the portal triad. In addition the vertical restrictions of the medial/anterior stomach wall were treated using a long lever technique, stacking the trunk into tension to facilitate the release. The transverse/vertical combined technique for the stomach in supine was also used with specific induction to release the anterior wall of the body of the stomach close to the lesser curvature.

Further GL was also to the stomach with local listening to the vagus nerve at the lesser curvature, specific intraneural release techniques to the vagus nerve were applied. Sphincters were checked and were functional. The projection of the celiac plexus was dysfunctional (rapid and erratic rate) and was treated with induction to slow down the amplitude of rotational motion; it was also balanced with the left frontal parietal zone to

improve communication between the CNS and visceral nervous system. Stomach motility was treated with induction into the direction of ease (expir) and both inspir and expir improved to above 80%.

In the 2nd session GL was on the left side, anterior and below the diaphragm in the lower abdomen. The GL was the same in sitting and standing and also found from GL examination from the lower extremities. LL was to the inferior/lateral aspect of leg one of the sigmoid colon with an extended listening to the posterior abdominal wall. The left SLR was mildly positive and noticeably improved with inhibition of the sigmoid colon. Mobility assessment revealed a significant restriction of leg one of the sigmoid colon when tractioning the lateral inferior edge of leg one up to the umbilicus. The sigmoid mesocolon was also restricted as when tractioning the sulcas towards the left ASIS it felt stuck and was also likely to be contributing to the left sciatic nerve irritation. On motility testing of the colon the sigmoid was restricted in inspir to approximately 50%. Leg one of the sigmoid was treated with induction (ease) and direct stretch. In addition the whole of leg one of the sigmoid was encouraged away from the posterior abdominal wall. Global release of the sigmoid tubes and sigmoid mesentery together was encouraged and scooped anteriorly off the posterior abdominal wall; a long lever technique using the left leg was used as was the forward lean position in standing in order to achieve a full release. Motility induction of the colon was used and inspir of the sigmoid colon improved to >80%.

Results

Following the initial treatment he felt significantly better, the acute upper abdominal pain had settled and the sciatica in the left leg was much easier. Following the second session the sciatica symptoms had completely resolved. He was given some lifestyle advice and it was suggested that if there was a deterioration of stomach related symptoms then it may be useful to consider further investigation to rule out the possibility of a stomach ulcer.