Barral Institute Case Study

Visceral Manipulation – Low Back Pain

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Last treatment session: 15th March 2017

Presenting Symptoms

This 59 year old female presented with a several year history of intermittent lower back pain that had worsened in the previous three months prior to her initial appointment, she also described bilateral hip pain and 'tension' in both the anterior and lateral aspects of her thighs. She reported having a significant fall off a horse in 2000 and felt her back problems may have started following this injury. Her symptoms were aggravated by sitting, stairs, changing position and lying in bed. Her past medical history included a skin disorder 'nodular prurigo' and she took strong immunosuppressant drugs (cyclosporine) to manage it, side effects were known to affect the kidneys. She also had a history of IBS and anxiety.

Initial Evaluation

It was observed that she had a mildly +ve trendelenberg sign with single leg stand L>R. Lumbar movements, extension and LSF were restricted. General listening (GL) was to the left anterior proximal thigh, this was also confirmed by GL from the lower limbs. Local listening (LL) was to the left femoral nerve just inferior to the inguinal ligament, there was an extended listening to the left kidney. The motility of both kidneys were noticeably diminished in inspir and expir. There was more tension and tenderness in Grynfelts triangle on the left compared to the right side. Left SLR at 65 degrees increased LBP and significantly increased to 80-90 degrees with inhibition of the left kidney; also right SLR at 80 degrees increased LBP on the left and improved with inhibition of the left kidney.

Treatment

Initial treatment was to the left kidney in supine and also with active contraction of the left psoas muscle to aid induction of the left kidney. The left kidney was also treated in side lying with extension of the left leg to facilitate release. The left and right lumbar plexus were treated in supine. The next GL was to the left pelvis posteriorly, LL was to the left sciatic nerve, inferior to piriformis. Treatment of the left sacral plexus initially was in sidelying to improve intraneural pressure and then progressed to a supine position with lower limb movement. The dura was treated in prone, using a double listening technique with a focus on the lumbar sacral region where the restriction was located.

In a following session GL was posterior, to the left and below the diaphragm, LL was again to the left kidney, specifically to the left posterior renal fascia. Motility of the left kidney was for the left kidney: 25% inspir and 15-20% expir and for the right kidney: 30-35% inspir and expir. There was a slight 2nd degree ptosis of the left kidney. Treatment was to the left kidney using breathing, psoas contraction and lower extremity movement (snooker cue

position) to aid release. The left renal vessels at the hilum of the left kidney were treated. The motility of the left kidney improved to 35 -40% inspir and expir. Following this a recoil technique of the left kidney was used and there was an immediate, and significant improvement of the motility of both kidneys to 80-85% inspir and expir, and also associated improvement in lumbar range of motion. Motility induction of both kidneys was used to aid integration of the nervous system. A further GL was anterior on the left just below the diaphragm and LL was to the fundus of the stomach, some transverse and vertical fibres of the stomach were restricted and were released.

Results

After 2 sessions she felt significantly better, her leg and lower back symptoms had completely settled and she had returned to doing some low impact gym work. The improvements in the motility of both kidneys had maintained when was evaluated a few weeks after the 2nd session. Improved lumbar movement and functional strength in one leg standing was also observed.