Barral Institute Case Study
Visceral Manipulation – Shoulder Pain
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Last treatment session: 9th June 2017

Presenting Symptoms

This 51 year old female presented with right shoulder and upper arm pain with significant restriction of motion of the right shoulder. In March 2014 she had a road traffic accident and following this developed a right adhesive capsulitis. In 2016 she had a capsular release of the right shoulder with significant improvement however in December 2016 she pulled a train door and developed a re-onset of right shoulder/upper arm pain.

Her significant past medical history included post traumatic stress disorder, at age 10 she was attacked and suffered major lacerations on her upper abdomen and chest and since has had problems with her bowel relying on laxatives to enable her bowel to function. In 2015 she had a total abdominal hysterectomy and clearance surgery for multiple fibroids (33) many external to the uterus. She also has a history of multiple chest infections.

Initial Evaluation

Initial general listening (GL) was to the right thorax in the midline above the diaphragm. Local listening (LL) was to the right bronchus. Right shoulder active abduction and flexion was limited to 100 degrees and passively limited to 110-120 degrees with a hard end feel, there was also a mild loss of right shoulder lateral rotation. Upper limb neurology was normal apart from slight weakness of right finger adductors (T1). There was a restriction of passive intervertebral motion of the thoracic spine at T3 level and more specifically at the right T3 costovertebral joint which was associated with the primary listening to the right bronchus. Elongation/mobility testing of the right bronchus was restricted. Motility of the right lung was restricted in inspir, particularly the right upper lobe which was limited to approximately 50% of inspir.

Treatment

Treatment involved release of the right bronchus, initially a double listening technique between the trachea and the right bronchial tube with induction and following this a viscoelasticity technique of the right bronchus was used to address further identified restrictions within the right bronchial tube. The right T3 costovertebral joint was also released in side lying. Further GL was to the anterior/inferior neck and LL was to the right pleural dome. On inhalation there was a noticeable increase in resistance of the pleural dome on the right side with an extended listening to the cervico-pleural suspensory apparatus on the right. Mobility testing of the pleural ligaments in sitting revealed a restriction of the right transverse pleural ligament (to C7) and also the right costopleural ligament onto the right 1st rib. Treatment of the pleural ligaments using a direct stretch approach was completed and breath was also used to facilitate the release. Further GL was

to the right anterior thorax and LL was to the horizontal fissure of the right lung, just lateral to the right sterno-chondral joint. Mobility testing of the right horizontal fissure demonstrated a significant restriction of motion, a focused direct stretch technique with breathing was used to encourage the release.

The next GL was to the right cranium and LL to the right frontal-parietal zone. Manual thermal evaluation revealed a right lung issue with an emotional component which was associated with the right frontal-parietal zone. Due to these findings and the consistency of a primary listening to the right lung region a technique was used between the right frontal-parietal region and the right lung using 'emit and receive' to address the emotional aspects of the restriction in the right lung, the goal being to release the line of tension between the brain and the right lung. Following this I worked with balancing expansion/retraction phases of the brain. Motility induction/balancing of the lungs was used with a focus initially on the right upper lobe encouraging expir in the direction of ease and then left and right lung motility was balanced.

Results

Treatment was over two sessions, at the end of the 2nd session the range of motion of the right shoulder significantly improved to full range elevation of the right shoulder (170 degrees +) improving from 100-110 degrees at initial evaluation. Inspire of the right upper lobe of the lung also increased to 80-90%. She felt a change in her breathing and was aware of a sensation of 'openness' in her chest that she hadn't previously felt.