

Manual Therapy Choices: A General Approach to Parkinsons Disease

By Leon Chaitow, ND, DO

In treating dysfunction, it is normal for most therapists to use a variety of modalities and methods including myofascial release, muscle-energy techniques, positional-release techniques and many more. The assumption must be that different tools achieve different effects, and the ones we choose reflect our perception as to the needs of the individual and/or of the tissues involved. Sledgehammers and walnuts are a reminder that there are appropriate and inappropriate tools for achievement of specific tasks.

A question arises as to whether there exists potential patient benefit to use a general, nonspecific, manual therapy approach, as well as specific focus on identified dysfunction (short, tight, restricted, etc). Evidence (see below) suggests that this is the case, particularly in situations of general poor health.

The variables as to why a particular method is chosen may include: how acute or chronic and how general or local the problem is; age, history and current overall health status of the person; known and/or hypothesized effects of the method in question in relation to identified dysfunctional conditions (i.e., the aimed-for objectives); and the skills, training and licensing restrictions associated with the person providing treatment.

Of course, if only a limited range of skills and modalities have been acquired, choice may be limited by that alone. In contrast, a therapist who has acquired multiple skills and a range of modalities from which to choose may be virtually spoiled for choice as to which therapeutic approach(es) to adopt.

I was reminded a few days ago of the importance that therapists acquire multiple skills when I came across a research study that evaluated a range of osteopathic methods (compared with dummy modalities) in the treatment of patients with Parkinson's disease (PD).⁴ In this study, 10 patients with Parkinson's disease and a group of eight age-matched normal control subjects were subjected to gait analysis before and after a

single session of an osteopathic manipulative treatment (OMT) protocol that involved mobilization and muscle-energy procedures rather than manipulation. A separate group of 10 patients with Parkinson's disease was given a sham-control procedure and tested in the same manner.

In the treated group of patients with Parkinson's disease, statistically significant increases were observed in stride length, cadence, and the maximum velocities of upper and lower extremities after a single treatment. There were no significant differences observed in the control groups. The data demonstrates that a single session of an OMT protocol has an immediate impact on Parkinsonian gait.

So, what methods were used (all of which are within the scope of practice of massage therapists, once they have acquired the skills)?

Antero-posterior and lateral mobilization of the thoracic and lumbar spine (patient seated).

Myofascial release of the thoracic spine (patient seated).

Atlanto-occipital release (patient supine; not manipulation).

Mobilization of the cervical spine (patient supine).

Muscle-energy technique (MET) release of cervical muscles (patient supine).

General mobilization of the shoulder joints including use of MET (patient side-lying).

Mobilization of the forearms (patient supine).

Mobilization of the wrists (patient supine).

Mobilization of the SI joint (patient supine).

MET to the hip adductors (patient supine).

MET to psoas muscles (patient supine).

MET to hamstrings (patient supine).

Mobilization of the ankles (patient supine).

MET to the ankle in dorsi and plantar flexion (patient supine).

Note: This sequence was performed in this order in 30 minutes.

Obviously (and the researchers note this), these procedures would probably have been even more effective if combined with approaches that targeted restrictions and dysfunctions specific to particular individuals.

However, in the context of a research study, it was considered that it would be useful to evaluate the benefits - or lack of thereof - when a standardized set of methods were used on all patients.

The outcome was clear. There is a major general benefit to be gained from a broad, generalized, constitutional approach involving myofascial release, muscle-energy techniques and mobilization. Would the results have been even more profound if they had been combined with massage or associated approaches such as Trager therapy and/or trigger point deactivation utilizing neuromuscular techniques? I would bet the farm - and more - on this!

References

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