

Manual therapy choices: The benefits of a general approach in – for example – Parkinson's disease

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In treatment of 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 tools, and inappropriate tools, for achievement of specific tasks.

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

The variables as to why a particular method is chosen may include

- How acute or chronic, and how general or local, a problem is
- the age, history and current overall health status of the person being treated
- the known and/or hypothesised effects of the method in question, in relation to identified dysfunctional conditions – i.e. the objectives being aimed for
- 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 approach(es) to adopt therapeutically.

I was reminded of the importance that therapists acquire multiple skills, a few days ago when I came across a research study that evaluated a range of osteopathic methods (compared with dummy modalities), in treatment of patients with Parkinson's Disease (PD). (Wells M et al 1999)

- In this study 10 patients with Parkinson's disease, and a group of eight age-matched normal control subjects, were subjected to an analysis of gait before and after a single session of an OMT protocol – which involved mobilisation and muscle energy procedures – not 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 demonstrate that a single session of an OMT protocol has an immediate impact on Parkinsonian gait

So what were the methods used – *all of which lie within the scope of practice of massage therapists, once they have acquired the skills:*

1. Antero-posterior and lateral mobilisation of the thoracic and lumbar spine (patient seated)
2. Myofascial release of the thoracic spine (patient seated)
3. Atlanto-occipital release (patient supine) [NOTE: not manipulation]
4. Mobilisation of the cervical spine (patient supine)
5. Muscle Energy Technique (MET) release of cervical muscles (patient supine)
6. General mobilisation of the shoulder joints (including use of MET) (patient side-lying)
7. Mobilisation of the forearms (patient supine)
8. Mobilisation of the wrists (patient supine)
9. Mobilisation of the SI joint (patient supine)
10. MET to the hip adductors (patient supine)
11. MET to psoas muscles (patient supine)
12. MET to hamstrings (patient supine)
13. Mobilisation of the ankles (patient supine)
14. MET to the ankle in dorsi and plantar flexion (patient supine)

All of this sequence was performed in this order, in 30 minute

Now 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 them – when a standardised set of methods were used on all patients.

And the outcome was clear....there is major general benefit to be gained from a broad generalised, constitutional approach, involving myofascial release, mobilisation and muscle energy techniques.

But would the results have been even more profound if they had been combined with massage (Hernandez-Reif 2002), or associated approaches such as Trager (Duval et al 2002), and/or trigger point deactivation utilising neuromuscular techniques (NMT)(Craig et al 2006),?

I would bet the farm – and more - on this!

References:

Craig L et al 2006 Controlled pilot study of the effects of neuromuscular therapy in patients with Parkinson's disease. *Movement Disorders* 21(12):2127-2133

Duval C et al 2002 The effect of Trager therapy on the level of evoked stretch responses in patients with Parkinson's disease and rigidity . *Jnl. Manipulative and Physiological Therapeutics* 25 (7):455-464

Hernandez-Reif, M et al 2002 Parkinson's disease symptoms are differentially affected by massage therapy vs. progressive muscle relaxation: A pilot study. *Jnl. Bodywork and Movement Therapies*, 6 (3):177-182

Wells M et al 1999 Standard Osteopathic Manipulative treatment Acutely Improves gait Performance in Patients with Parkinson's Disease. *Jnl American Osteopathic Association* 99(2):92-98