

Abnormal Scars as a Cause of Myofascial Pain Marc Heller, DC

I have long believed that the dominant chiropractic view of subluxation is much too limited. Most of us limit the scope of our manipulative treatment to spinal joints. Once you move away from strictly high velocity thrusts, enormous areas of the body become available to assess and correct via the adjustment. The soft tissues, all of the tissues that derive from the mesodermal embryological layer, all can be clinically significant targets for barrier assessment and correction.

In this light, I was excited to read Karel Lewit and Sarka Olsanska's article in the July-August 2004 issue of our own JMPT. Its title is Clinical Importance of Active Scars: Abnormal Scars as a Cause of Myofascial Pain. I have known and used these ideas for a long time, but having a description and set of case studies published in a prominent peer reviewed journal is a big step forward. I will review the article for you, and urge you to read the full text yourself. I appreciate JMPT, but occasionally find it a bit dry. This article is juicy, fully of wonderful useful clinical ideas.

Lewit begins by reviewing the history of Neural Therapy, which began in the 1930s with injection of Novocain into scar tissue, for pain that would be described today as myofascial pain. The effect of these injections was so rapid that they described the therapy with the German word "Sekundenphenoman," meaning effect within a second. Lewit traces the evolution of this concept, noting that dry needling, like acupuncture could produce the same effect, and adding manual soft tissue manipulation, as another tool to release scars.

Lewit reviews the importance of the soft tissues, noting that "every movement of the trunk or extremities is accompanied by a corresponding movement (stretch and /or shift) of the soft tissues surrounding muscles, joints, and bones. This is also true of visceral organs." He notes that impaired mobility of the soft tissues, especially fascia, can greatly impair motor function, contributing to trigger points and joint restrictions.

He then goes on to outline diagnosis and treatment. I'll quote again, "The moment the first resistance is met, the barrier is reached... For treatment, we engage the barrier, and after a short latency, release is obtained." He notes that in the abdomen, restriction can occur in several layers, and in several different barrier directions. This description is very similar to my own version of Engage, Listen, Follow, which I learned from the French osteopaths, particularly Barral. The keys include One; palpate to the soft barrier, not the hard end feel. Two: Engage the barrier, which means to keep this gentle pressure against the barrier and wait for a tissue response. Three; Allow the tissue to release, an almost passive process. I want to emphasize that if you want to release scar tissue in the abdomen, this gentleness, this respectful approach to the tissues, is critical for optimal results. I have always hesitated to teach visceral manipulation in my writing, as I believe it is best taught in a hands on manner, and needs a deep understanding of the softness of the approach, often lacking in the chiropractic paradigm.

Lewit talks about two major types of scars, one, more in the skeletal structures, where the scar is close to bone. The second is in the abdomen. He notes that the internal aspect of the abdominal scar may be far away from the surface incision. The surface incision is chosen for cosmetic, and muscle sparing reasons, the internal scars need to be searched for. This can be even more of a problem with the advances in surgery, where the more recent surgeries are carried out through small arthroscopic ports.

Lewit uses a palpation for barriers approach in the abdomen, emphasizing the assessment of the various layers, from the skin down through the various muscular and fascial layers. He gives a fascinating protocol, which I heartily agree with, for assessing the clinical significance and relevancy of the scar. Basically, you first assess the neuromusculoskeletal system in your typical fashion, finding and noting joint restrictions and myofascial restrictions, without giving treatment. You then find and treat the relevant scar, and then recheck the joint and myofascial restrictions. He states that “with some exceptions, everything will have reverted to normal.” The effect has to be lasting, and the patient should still be improved on exam two weeks later. Lewit describes his full protocol for correcting these scar tissue lesions, and describes a series of cases.

This protocol is a beautiful description of a priority-oriented approach. When you correct the primary subluxation, the secondary restrictions will often melt on their own. Yes, I am defining these scars as subluxations, neurologically significant soft tissue restrictions. If releasing the scar releases the joint restriction in the spine, it behooves us to assess and treat in this manner.

One of my remaining questions is what really happens to the scar when we “release” it. When I started studying visceral manipulation, I had the opportunity to glove up and observe in an open abdominal operation, on a patient who had experienced multiple abdominal operations. When I saw and felt the adhesions in his abdomen, with my own hands, it became obvious to me that my low force manipulation would not completely eliminate these very physical, strong adhesions. Yet, in my years of doing visceral manipulation, I have seen profound effects on multiple conditions. What are we doing to the scar? My suspicion is that part of the effect is mechanical, changing mobility to some degree. I believe that another, probably more significant effect is neurological. To quote Leslie Feinberg, of Neuromodulation Technique, “a more reasonable description is that the introduction of therapeutic manual force causes a reset of neurological circuits and releases the noxious stimulation to which the body was adapting.”

Lewit notes that resistance felt in deep tissues such as the abdominal cavity can be due to pathology or to an active scar. I’ll quote. “If, after engaging the barrier we obtain release after a short latency, the resistance “melting away,” pressure exerted by the therapist is no longer painful, and most symptoms have cleared up, we can conclude that an active scar is the cause. If there is pathology, no such effect is obtained and the resistance remains unaltered. We have repeatedly sent patient to surgeons (gynecologists) after this type of examination.”

I'll add that Barral and Roth both teach that there are many other sources of significant visceral restrictions. These would include trauma, where the heavy fluid filled organs can be moved suddenly. Infections can leave adhesions in the GI and respiratory tract. Other causes include repetitive daily motions, esophageal reflux, and the effect of emotional stress on the GI sphincters; all can lead to correctable restrictions in the chest and abdomen.

I'll quote Lewit again on his impression of the significance of this approach for our difficult patients. "If active scars are left untreated, they constitute a perpetuating factor which may frustrate all of our therapeutic efforts.

I hope this article sparks you to continue to learn, and to pay attention to a broad variety of soft tissue restrictions, and their effects on your patients. The international world of manual medicine has many contributions that can add to our therapeutic effectiveness.

Marc Heller, DC
mheller@marchellerdc.com
www.MarcHellerDC.com

References

Lewit, Karel and Olsanska, Sarka
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Quotes with permission of publisher

Barral, Jean Pierre
Visceral Manipulation
Eastland Press, 1986

Barral, Jean Pierre and associates
Visceral Manipulation courses through the Upledger Institute
1996-2003

Feinberg, Leslie, DC
First annual Neuromodulation Symposium notes
Sept. 04

Roth, George
Matrix Repatterning seminars