MFR Techniques

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(Special to the Forum)

MYOFASCIAL CERVICAL TRACTION—PART II

For the Relief of Headaches and Cervical Pain and Dysfunction

(Part One of this article appeared in the May 22, 1992 edition of the Forum.)

Cervical trauma, occusal discrepancies, TMJ dysfunction, stress, and malposition of the pelvis, lower extremities and feet change the position of the shoulder girdle in space. This alteration of the shoulder girdle in turn alters the foundation of the cervical spine, temporomandibular joint (TMJ) mechanism, and cranium. The resulting imbalanced foundation will cause pain and restriction of motion with a consequent change in function of this pivotal area.

Therefore, it is important to release and balance the lower extremities and pelvis, the thoracic area, shoulder girdle, and the upper extremities prior to attempting to balance the cervical area, TMJ mechanism, and cranium. Without this, all the good work you may do on the neck, TMJ, and cranium will be time wasted since the foundation structures will still be imbalanced.

Millions suffer from headaches and upper cervical pain and dysfunction. Billions of dollars are spent on aspirin, other more potent medications, and numerous treatment modalities aimed at alleviating or masking symptoms. But what about the cause?

The health professions' focus on treating symptoms has been woefully inadequate. Understanding and putting effort into resolving the cause-and-effect relationship are the answers to a true resolution of numerous complex problems.

Compression of the occipital condyles into the condyles of the atlas (C1) through trauma, forward head position, occusal imbalances, dural tube tightness, and an unleveled sacral base ultimately creates severe restriction of the fascia and muscular spasm, resulting in restriction of motion and pain in the upper cervical region, or tension or migraine headaches. Structural problems must be treated with a structural approach, not just in the specific area where the symptoms arise, but in all of the structures involved. This is why medication, modalities and joint mobilization and manipulation alone often are not sufficient to provide permanent relief. If one simply focuses on moving one osseous structure on the other, with no thought of fascial restrictions, the enormous power of the myofascial spans will pull the osseous structure back into dysfunction within a short period of time.

The osseous structures are passive elements, and their position is determined three-dimensionally by the balance or lack of balance of the myofascial spans. Therefore, it is not enough just to heat or stretch a muscle or mobilize bone on bone. Attention must be paid to the restriction of the fascial system.

Myofascial Cervical Release for Extension, Side Bending and Rotation

Position the patient off the table to about the level of T-5. Then with both hands cupping the occiput, gently and slowly traction the cranium cephalad. Maintain traction with one hand on the occiput. Place the other hand on the sternum and upper pectoral areas and push caudad (Figure 1). This will produce a three-dimensional release of the upper pectoral, hyoid, and anteroposterior cervical areas. Wait three to five minutes for a release, and allow the head to drop into extension. Never force the head into extension. Simply follow where and when the body is ready to move into this position.

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Please send your suggestions, case histories and questions along with your address and phone number to:

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Myofascial Cervical Traction—Part II

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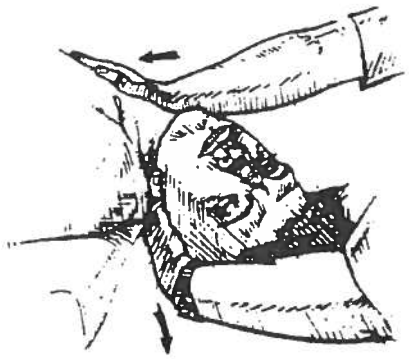
Figure 1. Maintain traction with one hand on the occiput and push caudad with the other hand on the upper pectoral area.

Force is never used with myofascial release at the end of the range. One waits at the barrier with sustained elongation until the release occurs. The body part will then move easily and non-traumatically into a new range.

Maintain traction by placing one hand on the patient's shoulder, allowing the cranial hand to move gently into side bending or rotation (Figure 2). Wait until there is a sense of softening and allow the head to continue to move into its new range. Then switch



sides and follow the same procedures.

Figure 2. Switch hands and maintain traction on the occiput. Rotate the head slowly to the left while the right hand pushes caudad on the right shoulder.

Sometimes the head and neck will seem to move spontaneously. This is the myofascial unwinding phenomenon. In other words, the body's inherent self-correcting mechanism is functioning. If and when this occurs, maintain light traction and follow wherever the body part seems to flow the easiest. This is the direction of ease and gives the sensation of water running down a hill. Allow the body to follow the path of least resistance until the corrections have occurred. When finished, maintain traction until the patient has slid back on the table and is properly supported.

My experience has shown that medicine, modalities, muscle energy techniques, mobilization and manipulation, temporomandibular joint appliances, massage, and flexibility and exercise programs affect the muscular and the elastic components of the fascial system. Only myofascial release affects the total myofascial complex.

This is why it is important to add these techniques to our current treatment regimens. Otherwise, we are only treating part of the problem and part of the patient. The inclusion of myofascial release allows conscientious health professionals to offer patients a truly comprehensive approach.

Myofascial mobilization techniques are effective in reducing pain and restoring motion and are designed to be combined with appropriate modalities, massage, mobilization and neuromuscular facilitation technique, exercise and flexibility programs.

Contraindications

Contraindications for myofascial release, such as malignancy, aneurysm, and acute rheumatoid arthritis may be considered absolute, while others, such as hematoma, open wounds, healing fractures, etc., may be regional.

malignancy
cellulitis
febrile state
systemic or localized infection
acute circulatory condition
osteomyelitis
aneurysm
obstructive edema
acute rheumatoid arthritis
open wounds
sutures
hematoma
healing fracture
osteoporosis or advanced degenerative changes
anticoagulant therapy
advanced diabetes
hypersensitivity of skin

NDT, sensory integration and movement therapies.

Reference

1. **Barnes, J.** *Myofascial Release the Search for Excellence.* Paoli, Pennsylvania: MFR Seminars, 1990.