



Therapeutic Insight

By John F. Barnes, PT
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Pediatrics

Dr. Viola Fryman has studied thousands of newborn infants. Her research shows that over 90% have distortions of either the cranium and/or the pelvis. Many of these important distortions do not self-correct, creating imbalances in the osseous and fascial systems. As the child goes through its developmental periods, the myofascial spans can then create imbalanced forces on the cranium and skeletal structures; the remodeling process can actually change the shape of the cranium, orbits of the eyes, the glenoid fossa of the temporo-mandibular joints, the facet joints, etc., setting the individual up for problems later in life.

The Myofascial Release Approach, therefore, emerges as a very important part of every therapist's regime in pediatric care. Myofascial Release's profound impact on the child's life and the pediatric cases that you and I treat daily is immeasurable and is illustrated in the following article, sent to me by Joan Faulkner, RPT, one of the finest therapists in the country. Joan has two private practices, one in New Haven, Conn., specializing in Cranio-mandibular and facial pain and dysfunction and the other, located at 116 South Main Street, P.O. Box 1568, Wallingford, CT, is for the treatment of acute and chronic pain dysfunction.

Dear John,

I thought your readers would be interested in hearing about a unique case I have had the pleasure of treating. This case shows the benefits of myofascial therapy and cranio-sacral therapy. Prior to my seeing the patient, she had been treated with traditional PT and OT.

History:

1/22/84- normal birth.

1/26/84 - 3/17/84- Tricuspid atresia and septal defects; pulmonary band surgery; GI tube for feeding.

4/14/84- infected cut down - arterial cath, second pulmonary banding - calcium infiltrate R arm, plastic surgery on arm; bilat. hernia repair.

8/2/84- problems with retching and gagging-gastrostomy & fundal plication surgeries. Complications off and on until 5/6.

Removal of pulmonary banding - repair of ASD and VSD.

7/11 - congestive heart failure.

8/1- mitral valve replacement repair VSD. Two hours post surgery severe bleeding from chest drainage tubes. Return to surgery.

12/16/85- admitted - GI problems.

5/4/86- admitted - vomiting and GI problems. Possible heart attack or stroke during 1st open heart surgery.

This two-year-old female was initially seen in this office 8/19/86 with a diagnosis of rate development and a history of congestive heart failure.

The patient was not able to walk or crawl. She was mobile only with a "scoot" on her buttocks and was just beginning an uncoordinated crawl. She exhibited externally rotated lowers in a supine position with decreased tone of the right upper and lower extremities. Scars are present on the right wrist, mid chest, left thoracic mid to lateral, bilateral anterior hips, and a gastric tube is present.

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Cranially, she presented with externally rotated parietals, flexed occiput and frontal, fast rhythm with decreased amplitude. Her right upper and lower extremities exhibited decreased volume in relation to the left, especially the right lower. Pelvic respirations were decreased, extension phase was also imbalanced, primarily right.

Treatment was begun with CV4s to lower legs, thighs and pelvis with emphasis on balancing right and left and increasing extension or internal rotation phase of the cranio-sacral system. Very gentle toe pulls were also done to attempt to loosen all scar tissue in hips and torso. It should be noted at this point that the patient still was not able to eat and hold any food down. Within the first two treatments of the above, the child began to assume an all four crawling position. Her desire to stand, holding on, also began to increase. By the fourth visit, the patient's mother stated that she had begun to eat and her stools had begun to change consistency.

Therapy was extended, gently doing lateral thoracic deep myofascial release and gentle deep myofascial release above and below hernia scars, gentle arm and leg pulls and direction of energy from occiput to sacrum and occiput to gastric areas. Gentle pelvic and respiratory diaphragms were also worked on along with balancing of occiput and sacrum to coordinate this motion. Within three weeks, the patient had gained 14 ounces and muscle bulk had increased in upper and lower extremities.

At this time, the child is walking with balance assist only, can walk short distances with one hand balance assist, crawls on all fours and can maintain a two point kneel. She pulls herself up on furniture by herself and walks holding on to objects. She is also attempting self standing. Eating has improved in that she is taking in small amounts of meat and potatoes. The gastric tube will be left in until she is able to take in enough nutrition to support her.

Visits were initially three times a week for 30 minutes, then as the patient had more energy (within two visits), therapy was extended to 45 minutes. Therapy was decreased to two times a week as she maintained cranio-sacral balance and better rhythm.

Goals consist of getting full extension phase of the cranio-sacral system, working more on the cranial component to balance this, continue scar release and myofascial until no more "pulling" is noted, and independence in gait. It is also hoped that through the above work, the child will eventually eat so that the gastric tube may be removed. I would like to add at this time that the doctors tell me that there is no known reason that she should not be able to eat.

I am also in the process of teaching her mother how to balance the cranio-sacral system and enhance it CV4s and she is also doing toe pulls and arm and leg pulls.

At this time, I have seen the child for 12 visits and cannot believe the progress she has made. No special treatment was done. The doctors are extremely pleased with her progress, and her OT, who hadn't seen the child for the summer, was surprised and curious with the patient's rapid progress. In fact, the OT is coming to observe her treatments.

I can only urge all therapists to extend and open their minds to the value of myofascial release and cranio-sacral therapy. These techniques, as you can see from this case, can be used in multitudes of diagnoses and should be considered a basic adjunct to all therapy.

Joan Faulkner, RPT

I am sure that the child and her parents are most grateful for Joan's caring expertise and I would like to thank her for sharing her experiences with us.

John F. Barnes, PT

Please send your suggestions, case histories, and questions to John F. Barnes, PT, "Therapeutic Insight," c/o Physical Therapy Forum/Occupational Therapy Forum, 251 W. DeKalb Pike, Suite A-115, King of Prussia, PA 19406.
