CAUTION WITH CERVICAL TREATMENTS

The Jones Institute teaches that there are no contraindications with Strain and Counterstrain technique. It has come to my attention that several people, including myself and other instructors within the institute, fear that this statement may lead the over-zealous practitioner not to monitor the patient as closely as must be done. Although it is true that, if the technique is done correctly, there are no contraindications to the technique, care must always be taken to monitor the patient for any signs and symptoms that would indicate that the treatment may not be appropriate for this patient or that the treatment needs to be modified in order to cause no harm to the patient. In Foundations for Osteopathic Medicine, DiGiovanna, Kuchera, and Greenman, report that Robert Ward, DO communicated with them a situation that has occurred with Strain and Counterstrain treatment. Anecdotally, one documented case of counterstrain related stroke has been reported in Europe during formal course teaching. A 38-year-old physical therapist, with unknown vascular disease but with many risk factors including smoking, sustained an internal carotid artery stoke after multiple classroom procedures. The complication was documented by angiography DiGiovanna et al. reports to take care to avoid combined upper cervical hyperrotation and hyperextension, and to stop treatment immediately if the patient reports any unusual neurological sensations.

I write this article because of an event that occurred in my office that recently came to my attention. A patient returned to my clinic, with a new condition of lumbar radiculopathy. The patient is a 64-year-old female with a history of diabetes. I had the opportunity to evaluate and treat the patient for 5 visits. On her last visit she reported to me, upon sitting up quickly, that she became very dizzy.

She related the start of these dizzy episodes to a counterstrain treatment that she had received in my clinic by a fellow therapist. Upon further questioning the patient reported that over the last year, since the treatment of counterstrain, that she has suffered these dizzy spells and she was currently receiving medical treatment for them. She has undergone angiographies, cranial MRI, and evaluation by an EENT without significant findings. Her current doctor had recommended she perform Brandt-Daroff exercises. Due to the fact that the patient was in a hurry to get to another test for the dizziness condition, I was unable to perform a thorough evaluation of the cause of her symptoms, however, I must assume that the patient's current physician felt that she suffered Benign Paroxysmal Positional Vertigo and prescribed the appropriate exercises for her.

The therapist that had performed the patient's evaluation, a full year earlier, took meticulous documentation. The therapist documented that the patient suffered pain in the right cervical, shoulder and upper extremity region. She had a history of high blood pressure, asthma, and diabetes. The patient suffered altered posture, shoulder limited ROM, upper extremity weakness, limited cervical ROM, and positive tests for shoulder impingement. On strain and counterstrain evaluation the patient was found to suffer INR, PLC4L, P1RR, A8CR, A8CL, BURR, and SUBR. The patient was treated with strain and counterstrain and became dizzy when coming to sitting from the supine position. The therapist reported that the symptoms subsided after the patient returned to the supine position and arose with the head turned. Upon returning for her second visit, she continued to complain of dizzy spells and was treated with MH, ES and strain and counterstrain to A3CR, A3CL, and P3C (side not specified). On he 3rd visit, a PTA treated the patient and the note does not report the patient complaining of any dizzy spells. All tender points were found on the right and treated. They were A4TR, A5TR, P4RR, P5RR, A5RR, INT5R, A7CR, A6CR, A3CR, L1CR, A1CR, A1CRR, P2CR, T3SR, MT2SR, LT2SR, and SUBSR. The same PTA attended to the patient on the 4th and 5th visit and no cervical complaints were offered and no cervical treatment was performed. The patient did not return for further treatment at that time.

In reviewing the patient's original findings and treatment, it is interesting to note that none of the initial treatment should have involved hyperrotation and extension of the cervical spine. Subsequent treatment of the third cervical level, which is documented to possibly treat vertigo,

was unsuccessful at resolving her symptoms. What is interesting to note, is that the patient is possibly believed to suffer Benign Paroxysmal Positional Vertigo (BPPV). BPPV is believed to be caused by displaced otoconia that has collected within a part of the inner ear. In performing the two most common treatments for BPPV, the Semont maneuver (liberatory maneuver) and the Epley maneuver (canalith repositioning procedure), the patient maintains a position for 3 minutes through each positional change. This is supposed to allow the otoconia, since it is heavier than endolymph, to float through the semicircular canal and ultimately to exit to the utricular cavity. This is what resolves the BPPV.

It is my hypothesis, not known to be fact, that in holding the patients position of treatment with counterstrain techniques it could have allowed the otoconia to become displaced into the posterior semi-circular canal of the ear. This may have then resulted in the patients dizzy spells. If this is the case, then the treatment with the Semont maneuver or the Epley maneuver, followed by correct instruction to avoid any posterior position of the head, and performance of the Brandt-Daroff exercises should afford the patient a 95 percent change of recovery. I am currently attempting to get into contact with this patient for follow up, however, at this time I have been unsuccessful.

The case study and the hypothesis outlined above are for educational purposes only. The exact cause of this patient's dizzy spells has not been diagnosed. The spatial occurrence in conjunction with strain and counterstrain treatment could just be random chance and not have any significance at all. However, the reasoning may help to identify and treat a condition that could occur in the clinic setting. The communication from Dr. Ward is a word of caution to always be observant to the patient no matter what the activity or treatment.

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