Neck Pain:
An Efficient Approach for the Busy FP

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Case 1

- Subjective: A previously healthy 28 year- old student carried her computer and her copy of F.O.M. in her right hand on the way to school. During the session she looks over her right shoulder to talk to another student. While turning back to look at the lecturer she gets a sudden, stabbing pain at the base of her neck on the right. It radiates to her right suboccipital and mid-scapular areas. She has no numbness or weakness in the extremities. She has had no night sweats, fever, chills, or change in her weight. She has no headache.
- Objective: Elevated first rib on the right. T2 FRSR. Posterior tender points at C3-5 on the right. OA is R_RS_L There are tender points at the superior, medial boarder of the scapula and in the body of the trapezius on the right. Reflexes and strength are normal in the upper extremities. Spurling test is negative.
- Assessment: ?
- Plan: ?

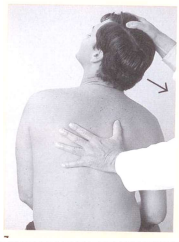
OMM Treatment Should Address

- Segmental articular somatic dysfunction.
  - (diagnosis and treatment with any OMM modality)
  - **Today- FPR and ME**
- Sympathetics and parasympathetic balance to the area (normalize upper thoracic spine and suboccipital area **(condylar decompression)**
- Fluid- if there is time
  - **Opening thoracic duct (MFR),** decreasing intramuscular pressure

SPURLING TEST

- Extend the neck.
- Side Bend to the effected side.
- Add slight axial compression.

This narrows the lateral foramen. Increased radicular pain or numbness indicates disc disease or foraminal stenosis.



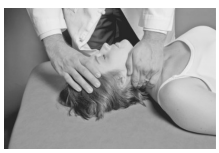
The Upper Thoracic Spine is the Functional Base of the Neck

One must often treat the upper thoracic spine and ribs as well as the cervical "long restrictors" before treating the neck itself. This is due to the musculature and also the sympathetic nervous supply to the neck.

SCM Scalenes Levator scapula

Cervical Soft Tissue

Longitudinal Stretch

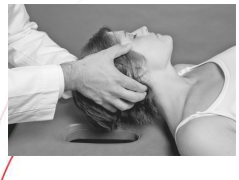


Lateral or Perpendicular Stretch

Strain Counterstrain (SCS) Posterior Cervical TP

- The patient lies supine. The patient's head may hang off the table to allow for further extension.
- Sit at the head of the patient and identify the posterior tenderpoint.
- Mark the posterior tenderpoint by your index finger.

SCS Posterior Cervical TP

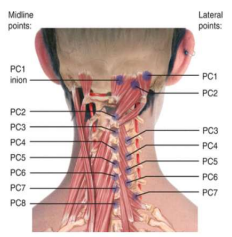


- Use the opposite hand to cup the occiput and provide the necessary head support for positional changes.
- Place the head in extension, with slight sidebending away and rotated away from the tenderpoint.
- Readjust the position to achieve the position of least tenderness.
- Hold the position for 90 seconds or until a release is achieved.
- Return patient back to neutral position without the help of the patient.
- Reassess.

Facilitated Positional Release

- From the SCS position:
- After the position of least tenderness is found, apply a facilitating force on top of the head in a direction through the cervical spine.
- Hold the position for **3 to 5 seconds** while the tenderpoint releases.
- Bring the patient back into a neutral position without the help of the patient and release the facilitating force.
- Reassess.

Strain Counterstrain TP of the Cervical Spine



AC1	Posterior aspect of ascending ramus of mandible at level of earlobe	Marked rotation away, fine tune with very minor flexion and sidebending away
AC2-6	On anterior lateral tubercle of transverse process	Flexed, rotated away, sidebent away
AC7	On clavicular attachment on SCM (on superior surface of clavicle)	Flexed, rotated away, sidebent toward
AC8	On sternal attachment of SCM (on medial boarder of clavicle)	Flexed, rotated away, sidebent away
PC1	Just below inferior nuchal line at lateral boarder of trapezius (1/2 way between midline and mastoid)	Mostly extended with fine tuning side bent away, rotated away
PC2 and 4-8	Inferiolateral aspect, tip spinous process of vertebra above (except C2 on superiorlateral of C2)	Mostly extended, with fine tuning side bent away, rotated away
PC2 (occiput)	On inferior inferior nuchal line within attachment semispinalis capitus	Mostly extended, with fine tuning side bent away, rotated away
PC3	Inferiolateral aspect of tip spinous process C2	Flexed, side bent away, rotated away

Cervical ME

- Stand at the head of the patient and place the second MCP of your hand on the side of the dysfunction on the articular pillar of the dysfunction.
- Induce **sidebending toward the side** of and **Rotate the head away** from rotational component of the dysfunction. Flex or extend to the level of the dysfunctional segment.
- Further introduce rotation and sidebending, contacting the restrictive barrier while maintaining the necessary extension or flexion.
- Instruct the patient to turn his or her head to neutral position against your isometric resistance, for 3 to 5 seconds.
- Instruct the patient to relax- Take the patient's neck further into the direction of rotational restriction. Repeat 3-5 times
- At the end of three cycles, take the patient into a final stretch toward the barrier.
- Return to neutral and reevaluate for motion of the segment.
- Note: AA is all rotation with only slight extension – rotate towards restriction pt rotates opposite