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Top-10 Positional-Release Therapy Techniques to Break the Chain of Pain: Part 2

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Top 10 Positional-Release Therapy Techniques to Break the Chain of Pain, Part 2

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POSITIONAL-RELEASE therapy (PRT) is advocated as an effective indirect therapeutic treatment for acute, subacute, and chronic somatic dysfunction.¹⁻¹⁰ Initial investigations have shown PRT to significantly reduce low back and hip pain²⁻⁴ and improve hip strength.² The effects of PRT are thought to occur from placing a patient's tissues in a position of comfort for an extended period of time.^{1,5-10}

In Part 1 of this column, in the September issue, we outlined the theoretical basis, general treatment rules, techniques and procedures, and clinical implications of PRT. We also illustrated 5 of what we consider to be the top 10 tender points and techniques for treating them (see the sidebar). In Part 2, we present tips for when

things do not go as expected, guidelines for patient self-treatment, adjunctive therapy applications, and the remaining 5 of the top 10 PRT techniques.

When Things Don't Go as Expected

Any therapeutic technique or tool is only as good as the practitioner applying it. It usually takes countless hours of practice over a period of years to become effective at PRT,^{7,8,11} but many of our students are successful in eliminating a patient's pain on their first few attempts. Even so, as with any manual therapy technique, the more you use it, the better "feel" you have for the correct application and desired tissue response.

When the desired clinical outcome is not obtained, we suggest the following tips:

- Reassess for additional tender points, proper positioning, or correct palpation, or treatment sequence.
- Try another position or technique variation.
- Repeat the technique again.
- Hold the position of comfort longer—it is advocated not to release the position until the tender point's associated fasciculation ceases or decreases significantly.⁵
- Release the position of comfort more slowly.
- Explore off the map; all TP locations or treatment positions have not yet been documented.
- Consider other causes of the pain—if no improvement is gained in three to five visits, reevaluate the root of the somatic dysfunction.

Top 10 Tender Points Treated by Athletic Therapists

10. Biceps
9. Intercostals
8. Hip flexor
7. Plantar fascia
6. Trapezius
5. Lumbar (Figure 1)
4. Posterior tibialis (Figure 2)
3. Cervical/Scapular (Figure 3)
2. Iliotibial band⁵ (Figure 4)
1. Patellar tendon (Figure 5)



Figure 1 Lumbar. Patient is prone, with pillow placed under thorax to midline. The athletic therapist rotates anterior hip posterior and toward midline, using more rotation for lateral points and with hip and knee flexed as alternatives.

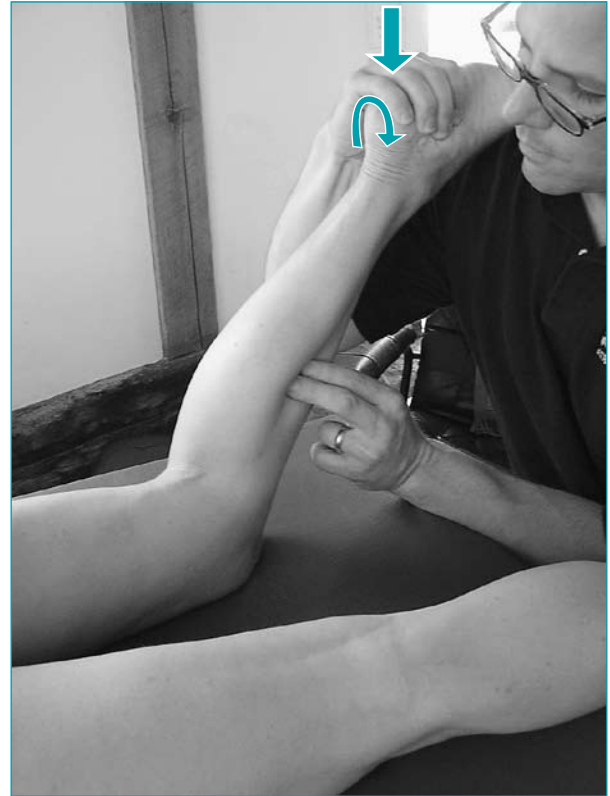


Figure 2 Posterior tibialis. Patient is prone with knee flexed $\sim 60^\circ$ and tibia supported with the athletic therapist's knee or shoulder. Place ankle in plantar flexion and apply calcaneal compression with inversion.

Patient Self-Treatment

Patient compliance is crucial to any successful treatment program. Some PRT techniques can complement a patient's at-home treatment regimen.⁵⁻⁹ Patients should be taught how to self-administer common PRT techniques. The inherent goal of PRT is to reduce aberrant muscle-spindle activity.¹⁻¹¹ When tissue tenderness or hypertonicity arises, patients can often treat the symptoms themselves to keep them from escalating until the athletic therapist sees them again. Instruct patients to put the affected body part in the position of comfort when they are in pain or icing after a treatment.

Adjunctive Applications

There have been many variations of the traditional strain-counterstrain, or PRT, techniques first developed by Jones.¹ Opinions on the use of adjunctive applications such as traditional modalities, joint mobilizations, and muscle energy to complement a PRT treatment vary, but it is generally accepted that once the tissue releases its tension, it should not be vigorously

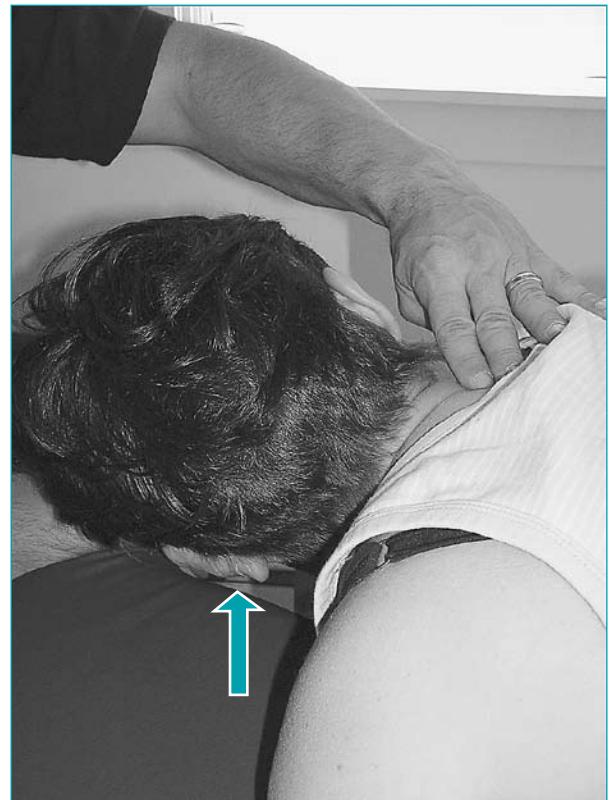


Figure 3 Cervical/Scapular. Patient is prone with arms at side, shoulders abducted to 90° , in cervical extension. Rotate and laterally flex away from tender point. Alternative: Perform with patient supine.

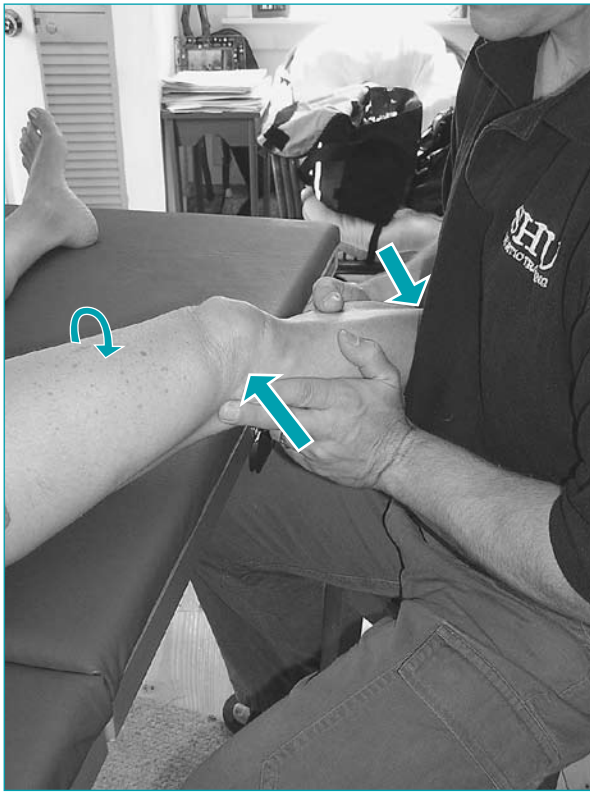


Figure 4 Iliotibial band.⁵ Patient is supine. Abduct thigh with external rotation and apply mild valgus force at knee.

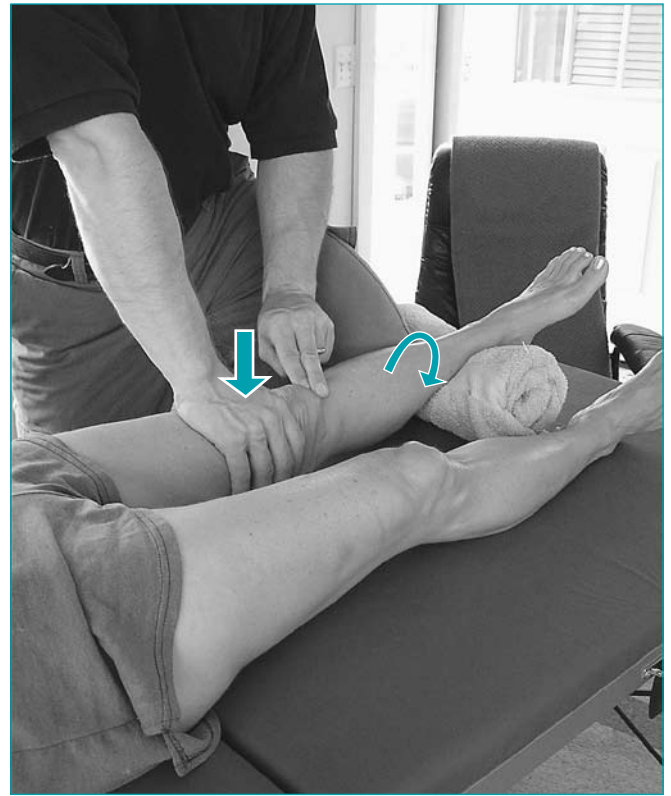


Figure 5 Patellar tendon. Patient is supine with towel roll under ankle. Apply posterior force above patella to produce hyperextension of knee and internally rotate to fine-tune.

exercised for 24–48 hr. This facilitates development of neural memory and reestablishment of normal tissue length.⁵⁻¹¹

Clinically, the practice of PRT and its therapeutic benefits have an established history. What is lacking is research into the neural and physiologic mechanisms of the process by which PRT alleviates somatic dysfunction. It can be tempting to view the technique as a panacea, particularly when patients and clinicians experience its powerful pain-relieving effects. Clinicians should consider PRT as one essential tool to be integrated into the overall plan to treat somatic dysfunction. ■

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