OMT in Challenging Co-morbidities: Obesity, Depression, Fatigue

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Synopsis

Musculoskeletal complaints in morbidly obese patients can be difficult to diagnose and treat, due to landmark location, mobility, and potential safety of the patient and the physician.

Physical complaints in patients with depression and/or fatigue can be multifactorial and are often vague.

This presentation will address caring for challenging patients, using safe body mechanics, distinct palpatory skills, and specific communication techniques designed to improve the effectiveness of the patient encounter.

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Objectives: At the conclusion of this presentation, the participant will be able to:

**Identify** common somatic complaints in patients with depression and fatigue;

**Demonstrate** the use of proper body mechanics when treating obese patients for the safety of the patient and physician;

**Recognize** somatic dysfunction in patients that may contribute to symptoms of depression and fatigue

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NEVER

Compromise your own body mechanics and hurt yourself!!
Why Treat?

Cannabimimetic Effects$^{1,7}$

Pain Biomarkers$^2$

Restore Autonomic Function$^3$

Optimize the functioning of the structure$^4$

Reduce the “sickness response”$^5$

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OPP – Treating the WHOLE Person

Believe the patient has pain
Touch them – you may be the first medical professional to touch their pain
Listen to the CAUSE of their pain
Treat what you can with what you have
Treat their sleep
Encourage conditioning
Take a Thorough History

- Sleep?
- Pain?
- Stress?
- Mood?
- Injuries?
- Which began first?
Patient Intake Form

- Every visit. Scanned into EMR
- Compare at subsequent visits
- Can help to determine facilitated segments, by repetitive pain in areas.
- Can help to determine cause and effect
- Can help to determine compliance
Examination

OBSERVE – for asymmetric respiratory motion

PALPATE for spasm, dysfunction, asymmetry

LISTEN – for heart sounds, respiratory sounds

TEST for viscerosomatic reflexes – Adrenals T8-10

LOOK for Chapman’s reflexes
Depression

• Emotional reactions
• Significant restrictions around ribs
• How language reflects our bodies – “pain in the neck,” “Weight of the world on my shoulders,” “Been punched in the gut.”
• Anergy of tissues
Prolonged Depression Can Lead To:

- Insomnia
- Chronic pain
- Heightened sympathetic tone
- Decreased cognition
- Gastrointestinal difficulties
Chronic fatigue syndrome, is a debilitating and complex disorder characterized by profound fatigue that is not improved by bed rest and that may be worsened by physical or mental activity. Symptoms affect several body systems and may include weakness, muscle pain, impaired memory and/or mental concentration, and insomnia, which can result in reduced participation in daily activities.

Source: www.CDC.gov/CFS/
• COPD contributing to exercise intolerance
• Cardiac deconditioning or limitations contributing to exercise intolerance, autonomic dysfunction
• Chronic pain limiting mobility
• Anhedonia, decreased motivation
Formulation of a Treatment Plan

What is restricted?

What is contributing to the restriction?

In what order should the restrictions be removed?

REMEMBER, the chief complaint is not always where the restriction is focused!
Treatment Drawbacks

HVLA – patient may be too large to reach around for a double-arm thrust.

Counterstrain: may be difficult to successfully move patient passively into position of ease due to their weight.

Flexion: Redundant tissue may limit the amount of flexion positioning possible.

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Autonomic Contributions

Sympathetic Chain

Vagus

S2,3,4
Applied Treatments

- Optimize the functioning of the structure
- Restore circulation
- Improved lymphatic flow
- D.O. – Deliver Oxygen!
- Improve autonomic balance
Safety First, Last, and In Between

- Make sure your equipment can support the weight of the patient!
- Scales go to 350 lbs - Buckeys and other exam room equipment are keyed off of that. If your patient weighs more than the scale can read, be very careful.

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Methane from www.giss.nasa.gov

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Focus on the Center of Gravity

- Patient stays on the table, supine if possible.
- Patient may be seated, if there is orthopnea or Pickwickian syndrome.
- You have permission to use your imagination to treat people, based on your knowledge of anatomy and biomechanics.
Use the Long Restrictors - Isometric

- Patient is supine, knees bent.
- Place your forearm between the knees, hand on one side, elbow on the other.
- Have patient “Bring your knees together” for 3 seconds.
Using the Long Restrictors - Isometric

- Patient is supine, knees flexed.
- Hug the patient’s knees, or, with straight arms, hold the knees together.
- “Bring your knees away from each other.” Hold for 3 seconds.
Balance the Quadriceps

- The patient is supine. Drop the affected leg off the table.
- Provide a counterbalance on the opposite ASIS.
- Hold the affected knee, and have the patient isometrically resist by lifting their knee for 3 seconds.
- Stop, take up the slack, repeat at least 3 times.
- Make sure you do both sides, to avoid rotating the pelvis on one side.

This may also be used to anteriorly rotate a posterior innominate.

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Muscle Energy to the Hamstrings

- Flex the hip to 90 degrees
- Support the knee with one hand, the patient’s heel in your other hand.
- Extend the knee until you reach the barrier.
- “Push your heel down into my hand.” Hold for 3 seconds, take up the slack.
- Repeat at least 3 times.
Have the patient seated or supine.
Abduct the humerus to 90 degrees, in internal rotation (Same as “stop” signal for cyclists!)
Hold their humerus, and have them reach for their toes for a count of 3. (caudad direction, in line with their spine)
Relax, take up the slack, and repeat two more times.
Release the Scalenes

- Find the tenderpoint posterior to the medial clavicle.
- Flex, sidebend and rotate until tenderpoint is neutralized.
- Hold for a count of 90 seconds
- Passively come back to neutral, and recheck.
Anterior Pectoralis Minor Tenderpoint

- Counterstrain
- Treats ribs 2-5
- Tenderpoint is inferior to the clavicle.
- Two ways to treat it
  - Flex the head and neck, causing flexion and sidebending towards the tenderpoint
  - Depress the ipsilateral shoulder and adduct the humerus across the midline

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Last Rib

- Treat the rotational and sidebending components of the thoracolumbar junction
- Treat the quadratus lumborum
- Use the lumbar myofascial technique up into the lower ribs to release restrictions
  - Patient is prone. Practitioner stands at the contralateral side of treatment.
  - Grasp their ASIS with the flattened fingers of your caudal hand, and rotate the pelvis toward you.
  - Apply an opposite force to their lower rib angles, creating increased rotation
  - Have patient cough to assist in release.
- How could this be performed supine? Seated?
Rib Raising

- Respiratory assistance
- Fingers spread out along rib angles.
- Lift the rib anteriorly and bring it laterally when patient inspires.
- Lag behind the expiration and gently release
- Repeat until some improvement is noted.
- ALWAYS TREAT BOTH SIDES!!

How could this be performed seated?
Seated Suboccipital Muscle Treatment

- Have the patient seated comfortably
- Stand next to the patient
- Flex the patient’s head forward. Hold their head in place, with one hand/arm, and their upper back in place with your other hand/arm.
- Have the patient raise their head up against your resistance for a count of three.
- Flex the patient’s neck and head to the next barrier, and repeat the process two more times.
Supine Suboccipital Muscle Energy Treatment

Place the web space of your hand under the occiput. Place the palm of your other hand on the occipitoparietal sutures. Flex the patient to the barrier. Have the patient push their head back into your hand for 3 seconds, resisting OA extension. Take up the slack in flexion. Repeat two more times.
Use Your Time Wisely

You have their undivided attention while you are treating them!

- Talk self care
- “What are you doing to help yourself?”
- Get a commitment [www.youtube.com/watch?v=mwP1KA6OhfU](www.youtube.com/watch?v=mwP1KA6OhfU)
- Make a plan – how will they meet their commitment?
Fatigue and Depression

Help them pace themselves.

www.flylady.net - useful method to help people better plan their activities of daily living

Discuss how to achieve a new normal

Discuss how they may be mourning the loss of what they had

Exercise! www.noexcusesworkout.com

Even 6 minutes can make a difference!

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Obesity

- Take it one bite and one step at a time.
- “Eat a salad as big as your head twice a day”
- Show them simple exercises to build muscle
- www.noexcusesworkout.com
- Measurements and weight
- Is anyone sabotaging them?
- Get others on the team
What You Have Learned:

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Recognize somatic dysfunction in patients that may contribute to symptoms of depression and fatigue

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References


All anatomical figures are from:
THANK YOU OMED, DR. GRIFFIN, AND THE AMERICAN ACADEMY OF OSTEOPATHY. THIS WAS FUN!!!!

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