

Sharon Gustowski,
DO, MPH
October 20, 2018
TxACOFF
sgustowski@
hotmail.com

OMT for Elderly & Seated OMT for Upper Thoracics and Shoulder

Objectives

- Review indications and contraindications for performing OMT in elderly populations.
- Practice osteopathic techniques that can be performed on elderly patients in a seated position.
 - Seated Articular for the Glenohumeral joint (Spencer technique)
 - Seated Soft Tissue for the upper thoracics/rhomboids

OMT in Elderly Patients- Special Considerations

- Precautions- What are some?
- Mobility abilities
 - Position changes
 - Exercise capacity
- Skin fragility
- Muscle atrophy
 - Tissue texture
- Joint mobility
- Co-morbidities
- Contraindications?





Clinical Conditions to Examine for Somatic Dysfunction and consider performing OMT

- Minor injuries
- Recovery from surgery, as part of rehabilitation plan
- Deconditioning
- Arthritis
- What else?

OMT in Elderly Populations - Consent

- Who can give consent?
 - Type?
- Chaperone?

Documentation

- PE: Somatic Dysfunction findings
 - TART changes
- Assessment
 - Medical diagnosis
 - Regions of somatic dysfunction
- Plan:
 - OMT # of regions treated
 - Result of OMT (resolved, improved, unchanged)
- Billing/Coding
 - Somatic Dysfunction regions
 - # of regions treated
 - Modifier-25



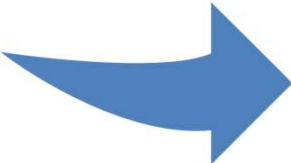
Why are Soft Tissue and Articular Techniques appropriate for Elderly Populations?

EVIDENCE

Knebl, Janice A., et al. "Improving functional ability in the elderly via the Spencer technique, an osteopathic manipulative treatment: a randomized, controlled trial." *The Journal of the American Osteopathic Association* 102.7 (2002): 387-396.

Twenty-nine elderly patients with preexisting shoulder problems voluntarily enrolled as subjects in this study, which was undertaken to determine the efficacy of osteopathic manipulative treatment (OMT) in an elderly population to increase functional independence, increase range of motion (ROM) of the shoulder, and decrease pain associated with common shoulder problems. Each subject had chronic pain, decreased ROM, and/or decreased functional ability in the shoulder before entering the study. Subjects were randomly assigned to either a treatment (OMT) group or a control group for 14 weeks. Over the course of treatment, both groups had significantly increased ROM ($P < .01$) and decreased perceived pain ($P < .01$). All subjects continued on their preexisting course of therapy for any concurrent medical problems. After treatment, those subjects who had received OMT demonstrated continued improvement in their ROM, while ROM in the placebo group decreased.

Soft Tissue Technique- Invitation to Practice



Spencer Technique

- Can be diagnostic as well as therapeutic
 - While performing technique, you are doing passive motion testing of the glenohumeral joint as well as improving motion
 - Pay attention to the motion in the joint as you are treating it
- Is commonly performed as an Articular technique
 - Articulating the humerus in the glenohumeral fossae as well as stretching shoulder muscles
 - Addition of muscle energy can be useful (*not on practical exam*)
- Improves range of motion of the glenohumeral joint
 - Does not correct one specific somatic dysfunction
- Usually needs to be performed every few days or weekly until resolution, as tolerated by the patient
- Often called the 7 Stages of Spencer

When to Use and When Not to use the Spencer Technique

Indications

- Any shoulder (glenohumeral) somatic dysfunction resulting in decreased ROM
- Adhesive capsulitis
- Rotator cuff strains
- Improve lymphatic circulation to the upper extremity

Contraindications

- See list in previous slide as well as:
- Absolute
 - Fracture of humerus, clavicle, scapula or other joint which may be affected by the technique
 - Muscular or ligamentous tears of the glenohumeral joint
- Relative
 - Post operative

Order in the Spencer Technique

- One of the few techniques which is performed in a certain order:
 1. Extension
 2. Flexion
 3. Abduction, Circumduction with compression
 4. Abduction, Circumduction with traction (distraction)
 5. A. Abduction
 - B. Adduction with external rotation
 6. Internal rotation
 7. Glenohumeral joint gapping/stretching

Note about pictures

- Some pictures have red arrows which indicate the patient force to be used if performing the muscle energy alternate technique
 - Not required
 - *ME alternate will not be tested on the practical exam*

Stage 1 – Extension

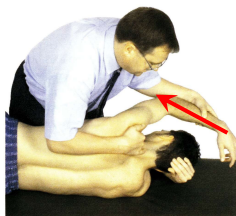
- Stabilize clavicle and scapula
- Flex partner's elbow and take the humerus into extension to the restrictive barrier
- Apply a gentle force into extension to improve range of motion
- Muscle energy alternate-
 - At barrier, have patient move arm into flexion while you are holding extension



Kimberly Manual (4732.11A)

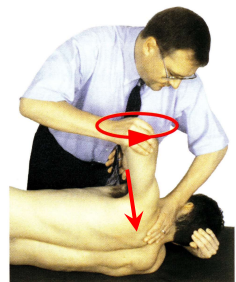
Stage 2 – Flexion

- Stabilize clavicle and scapula
- Flex partner's arm to restrictive barrier
- Apply a gentle springing force toward the restriction in flexion to improve range of motion
- Muscle energy alternate-
 - At barrier, have patient move arm into extension while you are holding extension



Stage 3 – Abduction, Circumduction with Compression

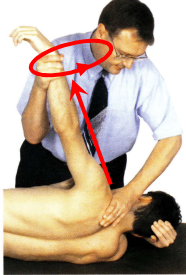
- Stabilize clavicle and scapula
- Flex partner's elbow and abduct humerus to 90 degrees
- Add mild compression into glenohumeral joint
- Hold compression and circumduct humerus in a clockwise direction
 - start with small circles and work into bigger ones in cone-shaped manner to larger circles to increase range of motion
 - Reverse directions
- Modify elbow pressure and direction so forces are directed at areas of restriction
- No muscle energy variant



Red= physician forces


Stage 4 – Abduction, Circumduction with Traction

- Stabilize clavicle and scapula
- Abduct humerus to 90 degrees with extended elbow and apply traction
 - Alternate- hold to be demonstrated in Lab
- Hold traction and circumduct humerus in a clockwise direction
 - start with small circles and work into bigger ones in cone-shaped manner to larger circles to increase range of motion
 - Reverse directions
- Modify arm traction and/or change circumference of cone so forces are directed at areas of restriction
- No muscle energy variant




Stage 5A – Abduction

- Stabilize clavicle and scapula
- Flex and hold elbow
- Abduct humerus to restrictive barrier
- Apply a gentle springing force toward the restriction in abduction to improve range of motion
- Muscle energy alternate-
 - At barrier, have patient move arm into adduction while you are holding abduction



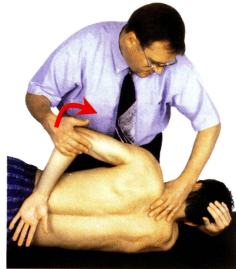
Stage 5B- Flexion, Adduction, External Rotation

- Stabilize clavicle and scapula
- Place partner's hand on your stabilizing arm by flexing elbow.
- Apply a gentle springing force toward the restriction in flexion, adduction and external rotation to improve range of motion



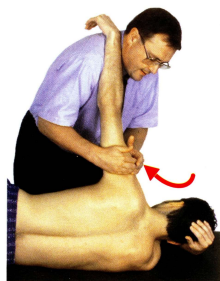
Stage 6 – Internal Rotation

- Stabilize clavicle and scapula
- Bring glenohumeral joint into internal rotation by flexing elbow and bringing hand posterior at the lower back region
- Pull elbow anteriorly to internally rotate the humerus into restrictive barrier- gently
- Apply a gentle springing force toward the restriction in abduction to improve range of motion
- Muscle energy alternate-
 - At barrier, have patient move arm into adduction while you are holding abduction



Stage 7 – Glenohumeral Joint Gapping/Stretching

- Extend elbow, abduct humerus and place pt's forearm or hand on physician's shoulder
- Place both hands on humerus with fingers spread over humeral head
- Intermittently apply caudal force to scoop humeral head from glenoid fossa and create general pumping motion of joint
- Aim pumping motion in any direction and repeat until better motion is achieved
- No muscle energy variant



**Last Step=
Retest Shoulder Range of
Motion**

References

- Hoppenfeld S. Physical Examination of the Spine and Extremities, Appleton-Century-Crofts, New York, 1976, pp 134-141
- Kimberly P. Outline of Osteopathic Manipulative Procedures. Millennium Ed. Walsworth Publishing Co. Missouri. 2000. pp. 235-8.
- Ward R. Foundations for Osteopathic Medicine, Williams and Wilkins, Baltimore, 1997, pp 969 – 1013
- Patriquin, David. The Evolution of Osteopathic Manipulative Technique: The Spencer Technique. Journal of the American Osteopathic Association, Vol 92, no 9, September 1992, pp. 1134-1146.
