Manipulative Treatment of Asthma.

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Section of Manipulative Therapeutics
A.O.A. Convention
Condensed noted from a symposium arranged by Dr. Perrin, T. Wilson, assisted by Dr. T. L. Ray and Dr. Harry W. Gamble. Compiled by Dr. T. L. Northup.

Dr. Ray said in his paper, which was read in his absence, that Asthma is a definite disease, in that it is produced by interference with the mechanism of respiration. The interference, because of the oversensitiveness of the nervous system, may be quite remote from the respiratory nerves and muscles but may just as definitely interfere with them as a more direct cause. This influence we feel is through the sympathic or autonomic nervous system.
Asthma is not the inability to draw air into the lungs, but it is an inability to expel the air. The force that governs the muscles of respiration is reduced and these muscles have lost their power to expel the air.
We wish to point out the osteopathic idea that the mechanical obstruction of the nerve force is the cause, and the removal of said obstruction is the cure. Dr. Still in his early life was afflicted with asthma and almost by accident he found that pressure on a contracted area in his back would relieve his attacks.
He reasoned that the pressure caused the relaxation of muscles and other tissues which had become contracted and were interfering with the nerves that control respiration.
We must search for the cause of the contraction. It may be in some remote part of the body. We have found it in bony lesions, in various parts of the body, as well as from disease in the different organs. We are of the opinion that an attack may be produced, in one who is subject to asthma, by a decided irritation to the nervous system in any part of the body. If this be true, one will readily see that the physician cannot succeed in a given case unless he finds the particular point of irritation and is able to successfully remove it. After the correction of the anatomical irregularities, it is absolutely essential that we give nature time to do the healing.

In the treatment of acute attacks we have been able to obtain very satisfactory results by inhibition or pressure on the spinal nerves of respiration, and assisting the feeble efforts to expel the air with a deep springing of the ribs inward on both sides with the hands on the lower ribs, quickly releasing when the patient was ready to inhale. This forces the old air out of the chest and makes room for a deep breath of fresh air.

The patients in many instances have shown their relief by normal breathing and offtimes have expressed it in these words, "My, what a relief!". In bad cases the motive

power of the chest is all but gone. There is a posterior curve in the dorsal spine from the first to the tenth. All of the area of the curve is so rigid that it is almost immovable.
As would naturally follow, the ribs are almost in a fixed position. One who thinks should see that this is primarily an obstruction to the powers of nature. The objectives are to re-establish motion in each individual joint of this part of the spine, to straighten the posterior curve and to restore the motive power of the chest walls. This is accomplished by plain corrective Osteopathic treatment of the A.T. Still brand.
Our objective in every case is the restoration of motion in the chest and the aiding of nature's efforts in order that pure air might enter. The treatment employed is the pumping treatment, as described for the acute attack, accompanied by very deep soft tissue work of a boreing character with the thumbs between the transverse processes and around between the angles of the ribs, as well as efforts directed toward loosening of all of the chest. Dr. Wilson amplified the description of Dr. Ray's treatment by saying, treatment must be continued over a long enough period of time to accomplish free mobility of the entire chest. This varies with different patients and may take three months or several years extending the time between treatments as the case permits.

The mobility of the ribs and vertebrae may well be accomplished by having the patient sitting on a chair or stool. Working on the right side we place the patient's right hand on the back of his head. The operator's right hand is placed on the patient's forehead with his right elbow locking the patient's right elbow. Rotation of the spine is obtained clockwise rotating the head and elbow at the same time the operator's left thumb loosens the tissues around the angle of the rib. You can see how the pectoralis minor and major raise the front end of the ribs through mechanical leverage, at the same time your thumb gets beautiful rib work. I have his elbow locked in mine. For pressure on his first rib get far enough forward. Many of us fail to depress or loosen the first rib by having our pressure too far back. See what a beautiful leverage you have here. Bend them back, as far as you want, and bring them around so that the pectoral muscles pull the front end of the ribs up. Get straight down on the first rib, not quite as straight down on the second rib and not quite as straight down on the third rib and so forth, pressing down the angles of all the ribs. We alternate to the left and do the same thing. My thumb is near the spine, just inside the angle of the rib. If the patient has a bursitis it may be necessary to modify the technique. You can feel the ribs move. To mobilize the vertebra, hold the one below the one you want to move and prevent it from rotating and pull the one above around on top of the vertebra you are holding.

As I understand Dr. Ray's treatment for the acute attack he suggests placing the hands on each side of the chest cage in the axillary line on the lower ribs to give a simultaneous pressure to aid in expelling the air at the time of complete expiration by the patient.

Just squeeze the air out. That can be done in almost any position. Complete mobilization of the chest and assistance with the expiratory movement to get out the dead air is the essence of the treatment.

Dr. Gamble in his very interesting paper said that over a score of years ago I discarded the use of any and all adjuncts and since then my reliance has been entirely upon manipulative measures in handling all the common diseases and conditions usually encountered in general practice in an industrial and agricultural community.

It is my opinion that the majority of all of our asthmatics as well as other chronic patients have already tried many drugs from hands quite as competent as our in their fields, so I hope to encourage the timid or less experienced to test thoroughly the manipulative osteopathy which should bring results unequalled by any other method.

It is always a satisfaction to me to get a patient with asthma who has not drugged too long or heroically, for the more medication they have taken, is just that much more of a handicap and they are just that much more difficult to cure, at least they demand a longer period of treatment.

You will be disappointed if you expect me to point out specific buttons to press to immediately relieve an acute paroxysm or to cure this distressing condition, for as yet I have been unable to find them.

After years or practice I feel that the pelvis and lower spine is a foundation which must be corrected before reduction of lesions higher up can be made and maintained. One of our London writer reports over 100 cases of asthma he has treated revealed bony lesions of the pelvis or 5th lumbar.

The Old Doctor said that he found it unnecessary to treat the average asthma case oftener than once a week. We know he did miraculous things in this field but I wish to treat most chronic cases of asthma three times a week for two weeks, then three times a week for a few weeks and then once a week gradually increasing the time between treatments.

A careful consideration of the vegetative nerves is important. Many of our results are so spectacular and immediate that it seems no other explanation is as satisfactory.

Many patients relate relief they have had from adrenaline chloride for their asthma. It does not require a very extensive experience to prove that manipulative osteopathy can and does normalize flow of adrenaline. The adrenals are closely related to the pulse rate, blood pressure and vaso-motor balance.

A well planned diet is important, only food that is easily digested and varied to provide a predominance of fruits and vegetables, avoiding very rich and indigestible foods, should be used. Patients of the catarrhal type often suffer nutritional disturbances, with the eliminatory organs failing to function satisfactorily. The best method of correcting poor elimination is by eliminating everything from the stomach that is harmful.

Dust, emotions, sudden changes in the weather, errors in diet, water intake, exposure, overwork, shock, mechanical injuries, dysmenorrheal and many other possible contributing causes may need consideration.

On the whole I have not depended much upon soft tissue work. It is difficult for me to feel that as lasting results follow soft tissue manipulation as with the deeper treatments which I consider more corrective of the causative lesions, yet during an acute attack one cannot expect to apply adjustive treatment, particularly when the tissues are in a pronounced spasm as is usually the case. Steady and deep pressure to the entire spinal area is indicated

until relaxation results. Taking the lower ribs at their angles elevating and separating them singly and in groups will help to give relief.

If the **cervical area** presents the fiddle string tenseness of the muscles they should be relaxed as well.

It is important to localize force and avoid such technic as twisting the entire spine with a pull on a shoulder and a push on the pelvis or the reverse or taking four or five spinous processes in one grab. I find it much more specific and effective to use less force directed to one or two vertebrae at a time.

I find patients appreciate a few moments treatment to the extremities in this and so very many acute and chronic conditions it is not difficult to attract the circulation to the cold extremities and by so doing we also help to relieve the congested organs. If the acute attack is not so distressing and rigidity of spinal tissues are easily relaxed I then spring the vertebrae to full range of motion, in various directions, especially in the lower thoracic area. I consider the areas above and below as secondary but not so specific, nor essential for relief. If my patient is in a satisfactory condition to receive stimulative treatment in this area before finishing my treatment, I give it.

There seems justification of the opinion that **treatment to the kidney area** also reacts upon the adrenals whose main center seems higher up. It is needless to say that those of the high nervous tension type who are frightened and worried should be given palliative treatment in the cervical area.

Most of us are called upon frequently to break up a threatened **pneumonia** and we know we succeed. I use much the same treatment applied quite the opposite in acute or chronic asthma. If stimulating treatment wore administered for acute asthma the patient would more than likely be more distressed than relieved for obvious reasons. When the tissues are tense deep steady pressure will give relief. The deeper and more firmly we apply our force the better results we will get.

Bronchial asthma should not worry or frighten us much, for it is in quite a different field than cardiac asthma yet who of you have not been thrilled at being able to give immediate relief in this more serious condition.

As to the prognosis and the number of treatments required you must realize that **every case is a law unto itself** and though many may be cured in a dozen treatments, some may require treatment covering many months or a few years. Two or three treatments per month should be frequent enough after the first few months even in very difficult cases.

Cooperation on the part of the patient is vital for many times you will discover that indiscretions, intemperance of all kinds, exposure and what not have been the direct cause of a recurrence so do not accept blame nor apologize for osteopathy in any case until you know it deserves it.

After reading his paper Dr. Gamble demonstrated his technique which briefly consisted of **correcting sacro-iliac and lumbar lesions** first **making sure that the legs were the same length**. He demonstrated several methods of technique, one of which we will include here: Many successful technicians a generation ago taught and practiced the principle of "exaggerate the lesion" and it has advantages supporting it, which many of us use from time to time preparatory to reduction or correction.

My experience and observation leads me to the conclusion that **the short leg** is most likely the one causing the most distress and it is my practice to treat the long leg first and finish up the treatment on the short or lesioned side, whether it be a 5th lumbar lesion or if it is the innominate in lesion. Adhering to the theory that one of the most universal and important characteristics of a lesion is restricted motion, I believe it is prudent to establish motion in all directions to full range of motion; using caution and judgment and time indicated by individual cases presented. Assuming **the right leg is the short or lesioned side**, I like to have the patient lie on that side, facing me.

With the patient's flexed knee in the abdomen of the operator whose fingers are placed on the 5th lumbar as a fulcrum pressing forwards while the operator throws his weight against the knee of the patient directing his force in such a manner that the muscular tension will tend to shorten the length of the limb on that side preliminary to the more important adjustment of the other side which is shortened.

In this same position the operator can accomplish considerable by using his right hand on the tuber Ischia and the left on the crest of the ilium and rotating the innominate and directing his force in the direction that would shorten the long leg.

With the patient still in this position the operator can stand behind the patient placing his right knee on the sacrum of the patient as his fulcrum and while grasping the leg of the patient by his left hand at the knee and directing his force on the sacral fulcrum in such a manner as to be a counter force to traction backwards and upwards on the extended leg in the direction indicated to shorten the long leg. All of the foregoing I consider more of a preparative technic to the adjustive technic on the short leg usually in lesion. So the technic is just reversed by directing the forces in the opposite directions in such a manner as tend to lengthen the short log.

So while the operator makes a fixed point while having the leg of the patient against his abdomen and his fingers on the 5th lumbar, the operator directs his force downwards on the short side while he throws his weight against the knee of the patient which is flexed on the abdomen and rocking backwards and forwards and making the flexed point on the 5th lumbar as stationary as possible.

Then the operator can place his left hand on the crest of the ilium and his right hand on the sacrum making a counter force downwards on the crest of ilium and making the fixed point on the sacrum with the right hand pressing upwards which tends to lengthen the short leg.

But the more effective technic with much more effective leverage is obtained by standing behind the patient lying on the long limb, using operator's right knee on the sacrum of the

patient as a fixed point and grasping the leg of the patient at the knee in operator's right hand, pulling downwards and backwards on the short leg while pushing upwards and forwards on the patient's sacrum by the operator's left knee which will lengthen the short leg. Nature is kind to us when we are not sure if the lesion is in the innominate or the 5th lumbar the muscle tension takes advantage of the constant tendency of Nature to resume the normal in practically all lesions.

He stressed the necessity of specific analysis of the lesions and specific technique for their correction. In the same manner he proceeded to demonstrate specific lumbar corrections taking one lesion at a time continuing up through the dorsal area paying much attention to rib lesions doing most of his work at the angle of the rib. He also noted that patients suffering acute paroxysms usually could not lie down and must be treated sitting up.

One such case that he reported was a patient eighty-five years old and had a trained nurse giving her hypodermics for five or six days. I started at the fifth lumbar and worked slowly and deeply and then I brought the spine to the right and left. I elevated the ribs, slowly and deeply and not too stimulating because she was in acute paroxysm. I worked on the cervical for restful relaxation and the woman went to sleep. I went three times a day for two or three days and she took a nap after each treatment where hypodermics or morphine would not give her relief.

My average treatment is twenty minutes. In asthma cases in acute paroxysm I may work for forty-five minutes but I think eighteen or twenty minutes is sufficient time for most chronic cases.

I had a case of asthma two or three years ago that I treated first about thirty years ago for a period of four months. She had kidney trouble, bladder trouble and neuritis for a number of years as well as asthma. The woman had been in pretty good health until about two years ago when she exposed herself badly. When they called me, the son-in-law said, "Mother is dying, come at once". I don't think I worked over thirty minutes and I said, "That is all. You report to me", and he came down the next day and said, "She is fine".

My average chronic asthmatics I treat as I do other chronics. I average three times a week for three weeks and then twice a week for two months and then once a week. As they progress and improve I spread the treatment farther apart.

Commenting on Dr. Gamble's paper Dr. Wilson said, "One thing which I noted in his work was versatility. I notice that in all of the older operators. If they can't do a think one way they have another way to do it. That does not seem to be particularly so in the younger operators".

Dr. Wilson said, "The treatment of asthma by manipulative therapy divided itself into two parts, the treatment in the acute stage and treatment in the chronic stage". Just remember that **there is a balance between the vagus nerve and the spinal nerves or what we call the para-sympathetic and sympathetic.**

Usually if we get a history of hay fever or disturbances starting with hay fever your treatment can be most effective with the occiput and the sacrum. If it starts with bronchial symptoms, it can be most effective in the bronchial area between the shoulder blades.

The cardiac asthma cases which develop in later life require still a different type of treatment. The occiput may be very important and the deep inhibition and traction to relax the muscles attached to occiput may be necessary.

We grasp the **sub-occiputal area** with our thumb and finger and use counter-force by grasping the bridge of the nose and approximate the hands using a steady pressure, frequently extending the head on the atlas, follow this with inhibition to the sacrum. If the primary cause of this acute spasm is dysfunction of the pituitary gland or a hay fever background, this may be the most effective way to stop an acute attack. If you are treating the bronchial type and the patient has never had hay fever use deep inhibition between the fourth and fifth transverse process on the right side. In the acute asthmatic frequently we cannot move the patient but we can use deep inhibition between the fourth and fifth transverse process on the right side. I get my foot under the left axilla. Nearly always these spasms in asthma, even though they are caused by a metastatic growth in the lung or are cardiac in origin, or whatever they are due to, have the fourth dorsal vertebrae drawn up to the right and with that the fourth rib. **You twist the four upper dorsal toward normal alignment.** Turn the head to the right side, bend the body to get the upper dorsal lined up and just hold that thumb between the fourth and fifth thoracic vertebrae on the right side. Just sit there and hold it. It may take fifteen minutes and it may take half an hour.

Occasionally it will be on the left side and if you palpate those tissues, you will find a muscle spasm which will tell you which side to work on, but I would say that in nine out of ten cases you will find that muscle spasm on the right instead of the left.

In the acute stage, if you are fast enough, you may take a definite adjustment with relief, but the majority of us are a little bit too slow and are apt to make the condition worse. I don't advise it although I do once in a while use a quick definite thrust in an acute attack.

You can also **normalize the nerve supply to the pituitary and often the vagus nerve** from another technique which I will show you for **adjusting the occiput**. Most of these cases are curled up in the dorsal area and have the head back. That in itself narrows the chest and the occiput is anterior on the atlas. With the patient sitting up that can be relieved by placing the thumb along the transverse process of the atlas. The thumb is placed parallel to the right arch of the atlas with pressure on the transverse process of the atlas way deep up underneath the occiput. Tuck it up until it fits right up underneath the occiput. The position of the operator's body is very important. It must be anterior to the left ear on the lateral side of the forehead. It is a wrong position if you are back where the body pressure will come on the side of the head. Re-inforce your thumb with your other hand and you have that joint between the occiput and the atlas so fixed that it alone moves. With a lift and rotation with your hands to the left and your body rotating the head to the right you rotate the occiput back and with it at the same time you will relax that vagus nerve which is being interferred with by the transverse process of the atlas.

The operator can feel definite movement directly between the occiput and atlas. You are turning the occiput back. If the occiput slides forward it also extends a little and lateral flexes to the other side. This technique will accomplish three motions, pushes the occiput back, lateral flexes to the same side and flexes the head anteriorly by the lift on the occiput.

For **specific correction of upper rib lesions**, the patient is asked to lie on his face and then up on his elbows. The doctor stands at the left side of the patient with his body at the patient's left shoulder. The doctor's left hand is on the patient's head (the very top of the head) the patient's face is turned to the right and the neck is side-bent to the right. The doctor's right hand is placed on the right transverse process of the fifth thoracic vertebrae. In this position a thrust is made directly approximating the doctor's two hands. When motion is established keep the left hand in the same position but change the right hand to the left transverse process of the fourth thoracic vertebrae and push it up toward the head. Now with the right hand go back to the angle of the right fourth rib and draw that rib down. Then drop to the angle of the right fifth rib and tease it upward. Again with the doctor's right hand cross to the angle of the left fourth rib and tease it upward, after which press the angle of the left fifth rib downward.

This technique will rotate the spines of the four upper dorsal vertebrae to the left, relieving the strain between the fourth and fifth. It will also approximate the fourth and fifth ribs on the right side and separate them on the left side.

Now then, don't forget because I am not mentioning general treatment that the entire spine must be lined up from the bottom to the top to hold it.

Relaxing the upper dorsal pressure on the lateral ganglia can usually be done if the patient is not dizzy or not a touchy patient with a bad arteriosclerosis by having the patient on back and by bringing the head over the head of the table and in the cardiac asthmatics between attacks I can do this and with all elderly people I use this technique provided it doesn't make them dizzy. I draw the patient off the table to the point where the third spinous process is just off the table and I slowly and carefully hyper-extend with traction by grasping the occiput in my fingers and a slow extension, bringing it up, allowing it to rest a second and come down again. The traction is mostly on the occiput. This is done for most cardiac cases of asthma and all elderly persons providing they can stand it. If they can't, some other technique may be necessary to get that back.

You very rarely find an anterior upper dorsal in asthmatics and I haven't happened to notice an anterior upper dorsal with cardiac complications. It is usually the flexion upper dorsals that give us our cardiac complications.

The question was asked, "Do you ever see nodules along the upper spinatous muscles in an asthmatic condition", to which Dr. Wilson replied, "Yes, that is due to hyper-activity and congestion." Actual relaxation and manipulation to the muscles as Dr. Gamble so cleverly showed will help to reduce those nodules. I don't think that is particularly in asthma but in a great many cases you will find those nodules.

Discussion followed that brought out the fact that pulmonary tuberculosis and asthma are seldom, if ever, associated.

Dr. Wilson said, "I don't believe that there is any indication that they are associated". Very frequently when you have acute bronchitis your asthma goes out. If you are sick anywhere else you are apt not to have asthma. If you have a case of acute bronchitis with a high fever and you treat it osteopathically, your patient will not be apt to have asthma for quite awhile. A great many children have asthma because of the poor treatment of pneumonia when they were young. As I have said, an adult gets lobar pneumonia and he gets a segmental break three or four vertebrae below the fourth. If a child is treated by an osteopath in bronchial pneumonia it probably-will not develop asthma. Occasionally it isn't the fourth dorsal, it may be anywhere in that dorsal area.

There was a boy who fell off a bicycle and hit his head and forehead causing a sharp hypertension. He buckled the third dorsal. It was a straight **anterior third dorsal** and that was discovered osteopathically after two years asthma and the asthma left after it was corrected. It took about twenty-five treatments.

That was an **anterior condition** and those anterior conditions I haven't mentioned. There are many ways to get at that condition.

Put a pillow between your chest and the patient's back bending the head forward then with pressure on the head buckle them back, localizing the area to the one that is anterior. Try to localize your pressure so that it will be teased out.

Now, in Dr. Ray's paper which I gave you a resume of, he spoke about **the difficulty of expiration and that can be helped** with the patient face down and up on the elbows. In that position grasp the lower ribs with both hands and right at the end of expiration, when he gets all through with it, come down on the ribs forcing the air out, and then let him come up with you. Try to follow the respiratory rhythm. Got it just at the point of complete expiration because at that point there is a relaxation before he comes in again and if you can catch that point it is so much better. That is true with artificial respiration. The most effective time for that squeeze is right at the end of the expiration, not while it is going out or just as it is being brought in. We climb right up on the table and straddle the patient if it is easier.

As a rule I do not ask a patient to relax. If I *see* they are tense, I move them a little bit. I feel if I have to ask a patient to relax there is something wrong with me that I am not relaxed myself.

I had a letter from someone who has used this elbow technique a great deal and he found that in this position if he went down each rib he got better results than if he stuck particularly to the fourth emphasizing what Dr.Unverferth said about the value of a general treatment. He would have the patient in the elbow position and put the spine through its normal range of motion by holding the head taut with one and going down the transverse processes with the thumb of the other hand, just work down the spine. This is one of the most effective ways of softening up that whole thorax you ever saw. You can go way down to the 12th and on the other side. You can get wonderful mobility because your spine is

suspended as in a hammock. I do a great deal of treating in this position. Taking the ribs, you separate the angles of the ribs in the same way.

Cardiac asthmatics are worse because they have a deficiency in the muscle of the heart and I feel that one of our great drawbacks is that we are too kind to our patients and try to cure them while they are on their feet. Many of these asthmatics should go to bed and stay there until the spasm is over if it takes a week or takes a month. **Go to bed and stay until they get over their acute attack**. Even a chronic, if you could put them to bed, would do better. Economically you cannot always do that, but you will find that your treatment is much easier and they will get more relief when you can.

Discussion followed that indicated the value of diet regulations and detoxification in acute cases. The general opinion with reference to the allergic cases were due primarily to vaso motor and pituitary disturbances. Dr. Wilson mentioned a nasal screen developed by Dr. Harrison J. Weaver for protection against pollens.

Dr. Wilson said in closing, "I believe that allergic asthmatics are strictly pituitary cases. Bronchial asthmas are due to old infections that were not taken care of osteopathically, or in any other way as far as that is concerned. If the patient has a "wasp waist" try to flare out the lower ribs by hooking under them with your fingers and on inspiration pull the ribs laterally. On expiration compress them".