

Variety

How many ways are there of releasing an inappropriately tight hamstring?

For the past several years I have been 'collecting' methods and at the last count the list exceeded 25, with little sign of having exhausted the possibilities. This somewhat light-hearted collecting endeavour began as a classroom exercise designed to challenge bodywork students to try to think more laterally.

Methods for hamstring release, 'collected' so far, range from the obvious, including various stretching techniques, use of post-isometric relaxation or reciprocal inhibition, mobilization of associated joints, to less obvious methods such as release of the suboccipital musculature (this is apparently more effective than postisometric stretching of the muscle itself, according to research [Pollard & Ward 1997]) and use of the tonic neck reflex (by having the individual rotate the neck to opposite side to affected hamstring [Murphy 2000]), as well as other methods too numerous to mention in this context.

As the list has grown it has come to represent the range of choices open to therapists and practitioners confronted by all dysfunctional situations that require therapeutic input. There are always alternative choices, and tight hamstrings are of

course merely a single example of a dysfunctional state.

A look at other biomechanical problems allows for a similar exercise in 'how many ways are there to ...', to be carried out.

For example, what's to be done to normalize zygapophyseal joint dysfunction? When is it appropriate to release a restricted facet joint by direct manipulative action (high velocity low amplitude thrust), and when by other means, such as Mulligan's Mobilization with Movement (MWM)?

And are there yet additional choices for a facet joint restriction? Undoubtedly there are, and they range from the extremely gentle (e.g. positional release methods) to soft tissue approaches that focus on attaching musculature (e.g. multifidus). There may also be 'movement' and postural re-education approaches which could modify the dysfunctional state of a facet joint.

In this issue of JBMT we have a chance to evaluate several methods capable of being used in the context of treating a facet joint restriction. The most obvious and direct methods are discussed by osteopaths Gibbons and Tehan, who confront the issues surrounding the safe application of high velocity, low amplitude, thrust methods. The use of HVLA thrust methods remains controversial amongst those bodywork professionals whose focus is largely on the soft tissues of the body, who question the use of 'invasive' force, when lighter

methods may suffice? The answer may be that there are times (and just how often is open to debate) when soft tissue work, whether using Muscle Energy Technique methodology, or Myofascial release, or anything else, are not able to restore normality to a restricted joint.

Another option is presented by Wilson who introduces elegant physiotherapy approaches based on Mulligan's (1992) work, which allows release to occur by means of the patient's own gentle efforts, as the practitioner holds the restricted structure in a manner that allows release to occur spontaneously. NAGs (neutral apophyseal glides) and SNAGs (sustained neutral apophyseal glides), both aspects of Mulligan's MWM approach, can be rapidly effective in releasing facet joint restrictions. However, when they are not, for whatever reason, and the joint remains a key feature of a patient's dysfunction, what other choices are there?

Liebenson, approaches thoracic dysfunction from a chiropractic perspective, strongly influenced by manual medicine. In this issue he has contributed the first of a three part 'mid-thoracic' self-help series, in which specifically focused exercises can be used in rehabilitation of the thoracic spine. HVLA thrust would almost certainly play a part in Liebenson's therapeutic input prior to the introduction of exercises, if he considered this appropriate.

Hannon, blending chiropractic and Feldenkrais® thinking, also offers practical conceptual insights into patient re-education methods which differ from those advocated by Liebenson.

No single approach has a monopoly. Logic suggests that if the practitioner is trained in various methods, the choice should always be to employ the least invasive approach. It seems to be stating the obvious that the essential tools of the rounded practitioner should include skills in as wide a range of modalities and methods as possible, so that therapeutic

needs can be met. Clinical reality suggests that there are instances when either MEM, or HVLA thrust methods, or soft tissue methods/rehabilitation strategies, would be effective, and that sometimes a combination will be needed.

Hopefully JBMT's focus on presenting practical, clinically relevant articles, covering a variety of therapeutic choices, will continue to stimulate practitioners and therapists towards an interest in methods currently not being used, and will encourage training in these, or a willingness refer when appropriate, if such methods are

outside the individual's scope of practice.

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Editor

REFERENCES

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