Visceral Manipulation: Reviving A Vanishing Art

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Abstract

During the first half of this century visceral manipulation was a new and evolving therapy that has since fallen out of favor. Visceral manipulation is based on the concept that all of the viscera in the body are mobile and need to be able to move in an unrestricted fashion in order to allow proper function. Through infection, inflammation and trauma, it is assumed that visceral restrictions occur over time and can produce impairment of organ function. Using gentle manipulative techniques to release adhesions and restrictions, organ mobility and function have been historically and clinically shown to be restored. In some cases it has been possible to avert unnecessary operative procedures or to avoid and/or reduce drug therapies. This article looks at the history and current revival of this unique treatment, as well as the physiologic relationship of organ systems and how visceral restrictions can have a far reaching impact on health. It is proposed that visceral manipulation be included as part of naturopathic medical education and that more researchers investigate its effectiveness.

History and Background of Visceral Manipulation

The idea of manipulating organs to relieve illness and to achieve optimal health is not a new one. These techniques were in wide use during the early 1900s in this country. During that period it went by a different name: bloodless surgery. Based on past clinical experience and information, visceral manipulation (VM) is currently undergoing a revival both in the United States and France, the latter largely due to the efforts of French osteopaths. The leader in research and education in this field has been Jean-Pierre Barral, DO. The anatomical relationships and efficacy of VM described in his books have been verified through dissection and radiography, and have brought the practice of bloodless surgery to a new level of refinement (1).

An exhaustive search of the literature on this subject has yielded few current scientific studies. Little written material exists on VM, although there are several older texts on the subject. Below is a summary of these works and an historical review.

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In a text on bloodless surgery by Paul Wendel, ND, written in 1945, he relates that Benedict Lust, ND, the father of naturopathic medicine, requested that naturopaths develop bloodless surgery techniques and encouraged Dr. Wendell to this end (2). In 1934-35 Dr. Lust was a frequent visitor to a sanitarium where he assisted in bloodless surgery "operations." Although Dr. Wendell included spinal and extremity adjustments under this term, his text describes treatments for the heart, abdominal organs, kidneys and pelvis to correct malposition and reduce adhesions. He cites enteroptosis as a far-reaching cause of illness and suggests manipulation as well as muscle strengthening exercises to maintain these manual corrections.

R.M. Failor, DC, ND was a major proponent of manipulative medicine in McMinnville, Oregon during the 1950s. He preserved as well as expanded the soft tissue techniques brought to the US from Europe by Adolph Lorenz, MD at the end of the 1900s. Dr. Lorenz passed this body of knowledge on to Byron White, ND, another naturopath focused on manipulative techniques. Dr. White was Dr. Failor's teacher and imparted many visceral techniques described in his book, *The New Era Chiropractor* (3). Failor encompasses soft tissue manipulation, dietary and herbal therapies, homeopathy and osseous manipulation in his book. He also refers to another VM text,

The Science of Manipulative Surgery, written by S.L. Fielder, ND and W.H. Pyott, ND in 1955 (4).

Major Bertrand DeJarnette, DC wrote a book in 1939 entitled *Technic and Practice of Bloodless Surgery* that describes in detail methods of manual treatment of the viscera (5). His belief was that osseous and soft tissue distortions are the primary cause of disease. In the practice of bloodless surgery, he emphasized the notion of treating the whole organism in relationship to itself, i.e., "expressing systemic derangement rather than treating an isolated case of appendicitis or cholelithiasis" (5).

Dr. DeJarnette's indications for bloodless surgery resembled those expressed in other texts and are similar to some basic VM concepts in use today. Namely that adhesions need to be stretched and loosened, any tissues or structures impinging on the flow of arteries, veins and lymph pathways need to be freed, and that visceral spasms need to be released to ensure proper function and anatomical relationships.

Intra-Pelvic Technic or Manipulative Surgery Of The Pelvic Organs was written in 1926 by P.H. Woodall, MD, DO (6). His belief was that whether the inciting cause of tissue pathology of the pelvis was due to, for example, multiple pregnancies or a past infection, once the initial cause was resolved, the sequelae that often followed the inciting cause could be just as disruptive to normal function. His book focuses on the treatment of adhesions and pelvic displacements in detail as a means of restoring normal gynecologic function.

After the 1950s, there is very little written about visceral manipulation. It is unknown why this technique fell out of favor. Perhaps, the introduction of "miracle" medicines like sulfa drugs in 1937, the refinement of surgical techniques during World War II and the death of Benedict Lust in 1945 all contributed to VM's decline, as was likely true for naturopathic medicine in general (7).

Basic Concepts

The concepts discussed here are largely osteopathic but share a mutual belief with naturopathic medicine that, when the right impetus is applied to the body, it can precipitate the body's ability to restore homeostasis through its own means of self-correction. This intrinsic energy of the body to achieve homeostasis is referred to by naturopaths and homeopaths as the vital force. VM has been described by several osteopathic teachers as "the homeopathy of manipulation" (8, 9).

A major factor that affects the motion of organs, and is vital to recognize as a VM practitioner, is diaphragmatic movement. The diaphragm moves approximately 24,000 times per day; the up-and-down motion of the diaphragm pulls the abdominal contents along with it. As the diaphragm descends, it causes a slight compression of the abdominal viscera. The thoracic cavity, by nature, has a negative pressure and when inspiration occurs that pressure becomes more negative. This negative pressure causes the viscera in the abdomen to be drawn up to the diaphragm, as if to a magnet. This pressure gradient exerts less influence on organs farther down the abdominal cavity. For this reason, it is easier for the cardia of the stomach, for example, to be drawn up into the thoracic cavity as in the case of a hiatal hernia, than the duodenum or jejunum. Conversely, it is easier for the lower pole of the stomach or a kidney to droop or ptose lower than its normal anatomical location than a more superior organ like the liver or gallbladder, as they are more distant from the "magnetic pull" of the diaphragm (1).

The VM practitioner must consider connective tissue when determining whether an organ is able to transit its normal 3 to 4 cm range of motion. Connective tissue encompasses several different kinds of structures from serous membrane to the omenta, and on to the ligaments. All of these tissues are interrelated and in some cases continuous with each other. For example, the falciform ligament, that connects the liver to the diaphragm and the anterior abdominal wall, is basically a thin fold of peritoneum. The pleura, pericardium and peritoneum all control and facilitate the movement of the organs that are contained within them. The pleura contains the lungs, the pericardium contains the heart and the peritoneum contains the abdominal organs. Ligaments aid in suspending and holding organs in their place. Every organ (except for the kidneys) is dependent on ligaments for support, and they are held in place primarily by pads of fatty tissue. The omenta of the abdominal cavity also hold in place the organs that are attached to them. This review of anatomy demonstrates how large a role these connective tissue structures play in visceral mobility. Inflammation or adhesions of these structures can, for example according to VM theory, reduce the expansion of the lungs or restrict normal flow of bile through the common bile duct.

As people age and there is increasing laxity of the ligaments, gravity takes over and ptoses of the bladder, kidney, uterus and colon become commonplace (1). Returning these organs to their proper location using VM has been shown to relieve structural problems such as a constant backache, or a functional problem such as urinary incontinence (1) (see Table 1).

Evaluation of Organ Health

The main method of assessing a particular organ in VM is by evaluating its mobility. Assessing the lie of the organ and its connective tissue attachments determines in what axes the organ will be able to move. For example, where are the suspensory ligaments of the liver that hold it in place? What prevents it from lateral shifting or inferior ptosis? Developing the skills to answer these questions is invaluable for detecting various problems. Visceral movements within the body cavity are small, thus a thorough knowledge of anatomy is essential for precise evaluation. Once familiar with the possible planes of visceral motion, information about an organ's ease of movement, general laxity and muscular or visceral spasm can be gathered. Knowing what type of restriction is present helps determine what kind of visceral mobilization techniques are best employed.

The basic principles of visceral manipulation or mobilization are straightforward. Gentle, slow movements are used at about the rate of eight to 10 cycles per minute. In the case of ptosis or excessive laxity of an organ, the technique of gently tractioning the organ upward in a series of repeated, small lifts to ease it back into proper location is used. Rather than follow a straight inferior/superior plane, these movements must be executed along the organ's natural axis of movement. In the case of adhesions or viscerospasm, a technique of recoil is used. In

recoil the tissues are gathered up into a state of tension at the primary site of restriction and then the tissues are abruptly released, often in conjunction with the patient's exhalation (1). This "rebound" effect is believed to jump-start mechanoreceptors in the tissues that allow the organ to resume normal alignment, according to Paul Chauffour, DO (9). It has been reported by Chauffour and Barral that these manipulations also affect the surrounding tissues, neural reflexes, the autonomic nervous system and endocrine system (8,9).

Distal Effects of Restrictions

Perhaps one of the most interesting aspects of VM is the way in which a local restriction over time can negatively impact organs and structures distant from the original problem. This is referred to in osteopathic circles as the causal chain of restriction. By way of a scar or adhesion, the inhibition of normal motion can spread into surrounding tissues and result in debilitating diseases (1).

Andrew Weil, MD devotes a chapter in his book, *Spontaneous Healing,* to Dr. Robert Fulford, a 90 year old osteopath and describes him as a remarkable healer (10). Dr. Fulford's approach to healing is largely through manipulation of hard and soft tissue. In his book, *Dr. Fulford's Touch of Life,* he introduces the subject of healing by describing the plight of a 45 year old man who came to him with cardiac problems (11). After undergoing numerous medical tests, the patient's doctors were unable to find a reason for his experiencing symptoms of a heart attack. When Dr. Fulford examined him, he discovered that a leg fracture, surgically repaired years before, had formed fibrous tissue and was disturbing his gait and balance. The result was that this distortion in posture was causing subluxation of the cervical vertebrae and an impingement of the vagus nerve, with the end result being heart attack-like symptoms. Within four treatments the patient regained excellent health.

Treatment of an Organ

To illustrate VM, the stomach, an organ that frequently requires manipulation, lends a good example of what steps are required (see Figures 1-4). These techniques and clinical observations are based on VM by Barral and Mercier (1). First, a review of the stomach's attachments.

The stomach is attached to the diaphragm via the gastophrenic ligament; this ligament supports much of the weight of the stomach. The gastrosplenic ligament stabilizes the stomach laterally by attachment to the spleen. The lesser omentum attaches to the lesser curvature of the stomach and connects it to the liver. The greater omentum joins the greater curvature of the stomach to the transverse colon. In addition to these ligamentous attachments, the stomach contacts the diaphragm, esophagus, pancreas, left adrenal gland, left kidney, transverse colon and inferior duodenum (see Figure 1). By understanding these structural relationships, the importance of proper anatomical positioning of the stomach becomes clear.

A common and interesting syndrome of the stomach involves ptosis. Secretion of hydrochloric acid is stimulated by stretch receptors in the body of the stomach in the presence of food. During the condition of ptosis, the body of the stomach is almost continuously in a state of stretching thereby inadvertently triggering release of acid at undesirable times and may result in gastritis and eventually gastric ulcers.

A good technique for assessing stomach mobility is done with the patient seated on the treatment table with legs dangling over the side (see Figure 2). With the patient in a slight slouching position, the physician stands behind and positions his/her arms near the patient's left subcostal area. The edges of both hands are then gently inserted into this area and pushed posteriorly. While in this position, the practitioner rotates his/her hands to the left side where the tension of the gastophrenic and gastrosplenic ligaments can be checked for unusual palpable tension or pain. To the right can be felt the lesser omentum and pylorus to see how freely mobile they are.

Another means of assessment is done with the patient in a seated position where the lower border of the fundus can also be checked for ptosis. The lower border of the stomach should be roughly level with the pyloric sphincter. If the practitioner's hands reach much lower than this, then a condition of ptosis is likely.

The next phase of assessment is done with the patient lying on his/her right side so that the lateral aspects of the stomach can be evaluated (see Figure 3). Placing the pads of the fingers at the midline above the umbilicus while standing behind the patient, the practitioner exerts a gentle lifting of the stomach laterally. Here again, the ease of movement of the lesser omentum and pylorus is checked.

Techniques of mobilization can be done in the same positions as for mobility testing. While the patient is seated, corrections for hiatal hernias and gastroesophageal reflux can be addressed. One method is to place the thumbs below the ribs to the left of the midline so a gentle downward pressure can be exerted on the cardiac sphincter. This motion is repeated several times to pull the sphincter down and away from the hiatal region of the diaphragm.

Examples of Some Conditions That Can Be Treated with VM

asthma	incontinence
bronchitis	impotence
cholecystitis	intercostal neuralgia
constipation	irritable bowel syndrome
dyspareunia	kidney stones
dysmenorrhea	nervous depression
dysuria	pelvic floor pain
edema of the ankle	reflex gleno-humeral pain
gastric reflux	sciatica
gastritis	spastic colitis
headaches	temperomandibular joint dysfunction
hepatobiliary disorder	ulcers (gastric or duodenal)
hiatal hernias	varicoceles
hypertension	visceroptosis and prolapse (1) (3)
	visceral spasms

Table 1

Visceral Articulations of the Stomach

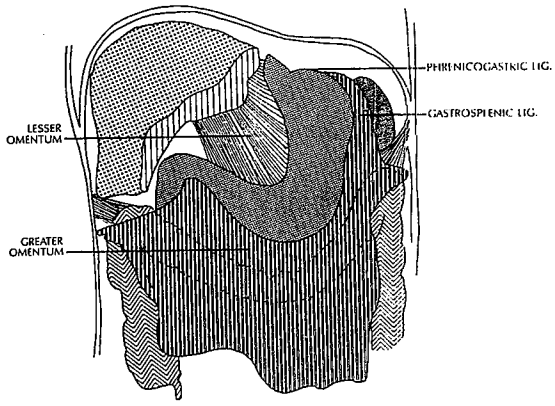

Figure 1

Direct Subcostal Approach to the Stomach-

Seated Position

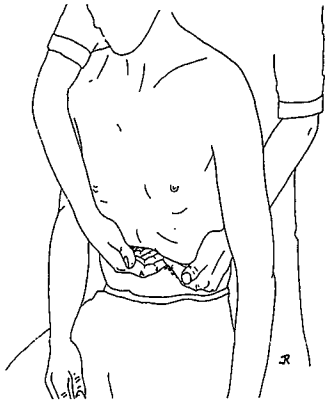

Figure 2

Manipulation for a Gastric Ptosis

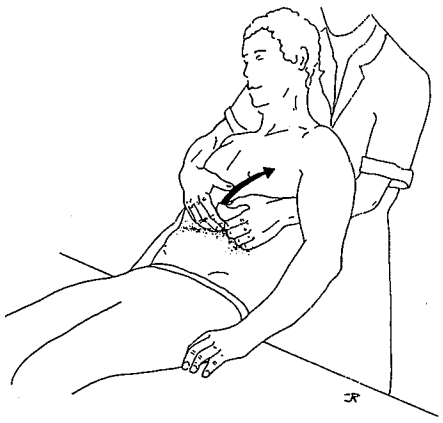

Figure 3

Mobility Test of te Gastric Fundus in the Right Lateral Decubitus Position

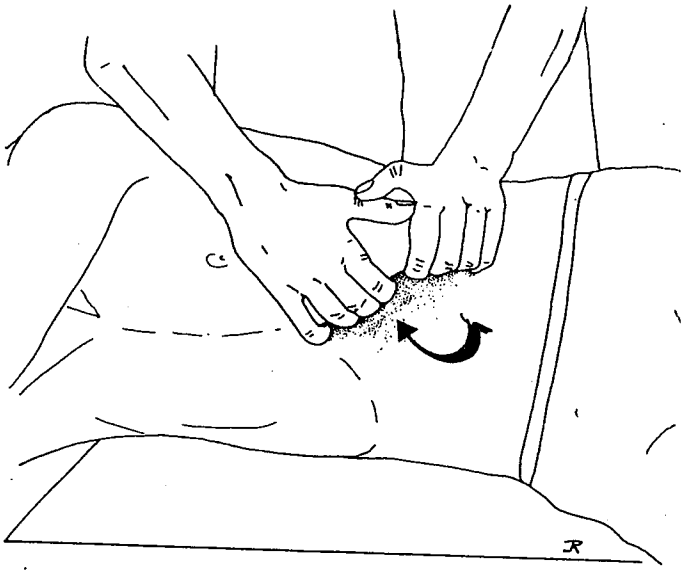

Figure 4

In the case of gastric ptosis, the patient remains in the seated position and the descended lower border of the stomach is gently tractioned upward in a series of repeated motions (see Figure 4).

While a patient is in the side-lying position, any lateral tension of the stomach can be addressed by placing one hand medial to the left ribcage on the upper abdomen with the other hand on the midaxillary line of the left ribcage. Then a gentle rocking of the stomach is done, first exerting pressure with the medial hand and then the lateral hand.

According to Barral and Mercier, problems often associated with the stomach involve the left temperomandibular joint as well as left sided sinusitis or left sided headaches. They also assert that problems specifically with the gastroesophageal junction can contribute to asthma. In children, they suggest, this is more often seen as nocturnal asthma.

Case Illustrating VM's Effectiveness

A 74 year old female presented with complaints of severe gastric and chest pain which necessitated calling 911 several times. Blood tests and EKGs performed in the emergency room revealed no overt cardiac involvement. The patient had previously controlled gastric discomfort by taking Pepcid™ and Tums™ on a regular basis. She was examined by her family physician and no abnormalities of the heart were found. Still, she was scheduled for a cardiac stress test with injection of thalium at the time of her visit for visceral manipulation.

Examination of the patient with visceral palpation revealed gastric ptosis to a severe degree and abnormal patency of the cardiac sphincter. Along with gastric discomfort, the act of leaning over caused her instantaneous reflux and esophageal burning. Derangement of the sphincter was thought to be affecting the fibers of her vagus nerve, thereby evoking both chest and gastric pain. Correction of this problem using only VM resolved the patient's acute complaints and the need for the stress test was thereby averted. Her family physician was content to wait and follow her progress.

Conclusion

Naturopaths of previous generations recognized the importance of ensuring free mobility of the organs to ensure their optimal functioning. Manual visceral techniques were in wide use during the early 1900s by drugless physicians in both the United States and Europe. For reasons unknown, it seems that these valuable techniques fell out of vogue and are on the verge of being lost to the naturopathic profession, a loss that is immeasurable.

Fortunately, several practitioners, naturopathic and others, are working to revive this vanishing art. Equally fortunate, physicians at an initial level of experience in VM are able to detect gross restrictions in the soft tissues, release them and in this way facilitate healing. Correcting restrictions and lesional chains allows a subtle "unraveling" of strains in connective tissue, organs or skeletal structures. This can result in a recovery process that can continue for several weeks on its own. That is why the frequency of VM treatments need not exceed every two to three weeks.

Naturopathic philosophy centers on forms of medicine considered to be non-invasive. Homeopathy, botanical medicine and physical medicine are some of the mainstays of the profession, all sharing a focus on gentle correction and encouragement of physiologic homeostasis. It is the author's opinion that reincorporating VM into the range of treatment approaches and combining it with other naturopathic or medical therapies will greatly enhance the effects of other modalities employed by physicians.

A patient's complaint of a lingering cough following a respiratory infection could be, for example, addressed more fully, perhaps, by releasing a restriction in the pleura using VM, prescribing an acute homeopathic remedy as well as a botanical or Chinese herbal formula to moisten the lungs or resolve phlegm. In a visit where most of the assessment and treatment is through verbal means, VM gives the practitioner an opportunity to apply touch, something that is missing in many physician-patient interactions. No other practitioner group has at their disposal the ability to combine this powerful technique so uniquely with other systemic therapies.

At this point in history, naturopathic practice often involves an intellectual process: patient interview, laboratory test interpretation, diet analysis and advise. Expanding the realm of manual medicine beyond chiropractic manipulation to include VM would further distinguish naturopathic manipulation from that of chiropractic. Secondly, adopting a manual approach that is organ-centered would reflect more accurately a philosophy of medicine that seeks systemic balance as its goal, as does naturopathy. The future and redevelopment of VM as a naturopathic treatment approach is dependent upon VM being incorporated into the naturopathic educational curriculum as part of physical medicine training and for its scientists to conduct research on its effectiveness. These two steps would ensure VM's future within the profession and restore an invaluable technique to the repertoire of naturopathic medicine.

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Biography

Marian Small is an ND, MAc and RN practicing in Seattle, WA. She teaches at Bastyr University Clinic and has taught workshops in cranio-sacral palpation for their acupuncture program.