Callidae Manus

RECOMMENDED PRODUCT

Practical Handbook

PERIPHERAL MANIPULATIONS

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Contenido

FUNDAMENTAL PRINCIPLES

The generic manual therapy's fundamental principles but also the peripheral manipulations that I am going to teach you are the self-healing and the relationship between structure and function.

- **SELF-HEALING:** The human body contains all the necessary (means/tools) to prevent and heal diseases. Anyways, the condition to make this happen, can take place just if all the self-regulation systems are free to work properly.
- **STRUCTURE-FUNCTION:** The possible obstacles which can be found, must be searched in the body structures, more precisely in the myofascial-skeletal system. After direct or indirect anoxic damages, the joints can suffer functional modifications that are the origin of most painful musculoskeletal conditions.

As in the Spinal Manipulations manual, it is important to describe the three phases of the manipulations. The manipulations I will teach then, are divided into three phases:

1. Establishing the correct position of you and your patient: This first step is fundamental and influences the success or failure of the manipulation..
2. Finding the so called restriction barrier: The barrier is the resistance you find while moving passively the chosen articular segment (or segments) to their limit.
3. Thrust execution: the thrust is the manipulative impulse; this is to say the push to perform against the restriction barrier. It is a quick micro-movement, almost always followed by a sound that in our jargon is called "crack".

This articular cracking sound, according to some research studies, is due to the cavitations' phenomenon, the creation of small gas bubbles dissolved in the synovial liquid because of the separation of the articular surfaces.

The thrust must never overcome the anatomical movement of the articulations, because it can create dislocations and/or musculoskeletal lesions.

DYSFUNCTION

The dysfunction influences the movement, before causing pain or creating harmful alterations to the organs and anticipates its influence on the movement even before increasing its number or dimensions. It occurs as an unbalance almost imperceptible that has often to be detected at articular level, evaluating the existence of locks or unbalances, or through the functional evaluation (movement restrictions). The articular lock and unbalances can be caused by traumas or external aggressions, or by internal functions alterations, that often are the starting point of several disturbances that gradually come out in the human body. The body tries to react to these locks through the first principle of the manual therapy, the self-healing, but if the aggressions are stronger than the body's defenses, a real dysfunction takes place.

DIAGNOSTIC

Diagnosis can and must be done only by a doctor, so in this phase we talk about **functional diagnosis** and not medical diagnosis, because the patient must have a medical diagnosis when he/she contacts you, if you are not a doctor but a physiotherapist.

Anamnesis: It helps to provide us all the necessary information about the immediate and remote patient's pathology. Obviously our anamnesis includes also the evaluation and interpretation of the instrumental exams provided, such as MRI and X-Rays.

Functional evaluation: It allows us to functionally evaluate the involved peripheral articulations. The main scope is to evaluate possible articular restrictions.

Palpation: This exam aims to the evaluation of the texture's consistency, by the hypodermatic textures tension highlighting if the area is sensible to the pressure respect of the surrounding textures.

Using the **peripheral manipulations** we must remember that besides the instrumental diagnostic it is important to have a global approach referring always to the pain mappings that you find in my video-course **Spinal manipulations.**

My advice then, is to always associate the **spinal manipulations** that I taught in the other course in order to address your patient to a prompt recovery.

FIELDS OF APPLICATION

General:

- Non recent sprain trauma
- Immobilisations
- Atricular degenerative processes in a non acute phase
- Periarticular post-traumatic and post-inflammatory calcification

Specifics:

- Painful shoulder
- Calcific or non calcific periarthritis
- Conflict syndrome or impingement
- Subacromial bursitis
- Adhesive capsulitis or frozen shoulder
- Rotator cuff lesion
- Shoulder dislocation outcomes
- Tendinitis or calcific tendinopathy of the rotator cuff tendons
- 2 degree Gleno-humeral arthrosis
- Tendinitis/over-spinal or long head of biceps lesion
- Epicondilytis/ mediale epicondilytis
- Gonalgia / mild gonarthrosis
- Meniscal lesion (conservative treatment)
- Twisted ankle outcomes
- Twisted knee outcomes
- Plantar fascitis/ Metatarsalgia
- Wrist tendinitis
- Carpal tunnel syndrome

CONTRAINDICATIONS

Even if this course is addressed only to doctors and physiotherapists I suggest to take the proper preventive measures before deciding to manipulate your patient, because his/her health must always be the first priority.

You must not manipulate without a medical diagnosis and without having checked the medical reports and images of the instrumental exams. Only having a clear medical diagnosis (that must be done by a doctor) you can put your patient's health first.

I remind you that you are responsible for your patient's health, so before manipulating you must make sure that no contraindications to peripheral manipulation exist.

Your patient must have a medical diagnosis, as it is fundamental to have a completely safe manipulative approach.

As for spinal manipulations, for peripheral manipulations it is necessary to distinguish the contraindications between absolute and relative.

Absolute contraindications:

- All the tumour diseases (primitive o secondarily, benign o malignant)
- Acute or chronic infectious diseases (spondylodiskitis, arthritis, Tuberculosis)
- Recent traumas (fractures, dislocations, sprains)
- Rheumatic diseases
- Juvenile osteochondrosis
- Acute osteoporosis

Relative contraindications:

- The patient is scared of manipulations
- The operator doesn’t master the technique completely

PRACTICAL PART

The manipulations you will learn are a mix of techniques inspired to osteopathy and chiropraxis redesigned by me thanks to experience, to make their execution easy and effective.

Before performing any manipulation, make sure that the patients has a medical diagnosis and no contraindications to peripheral manipulations exist.

SHOULDER MANIPULATIONS AND TREATMENT OF A PAINFUL SHOULDER

You have to know that this part of my method will make you unique and incomparable in treating the main painful conditions of a shoulder such as:

- Calcific or non calcific periarthritis
- Conflict syndrome or impingement
- Subacromial bursitis
- Adhesive capsulitis or frozen shoulder
- Rotator cuff lesion
- Shoulder dislocation outcomes
- Tendinitis or calcific tendinopathy of the rotator cuff tendons
- 2 degree Glenohumeral arthrosis if the arthrosic degeneration degree is moderate
- Tendinitis/over-spinal or long head of biceps lesion

I designed a valid and effective method for all the painful conditions that are described above. It deals with techniques and clinic reasoning that I learned together with my personal experience and experimentation.

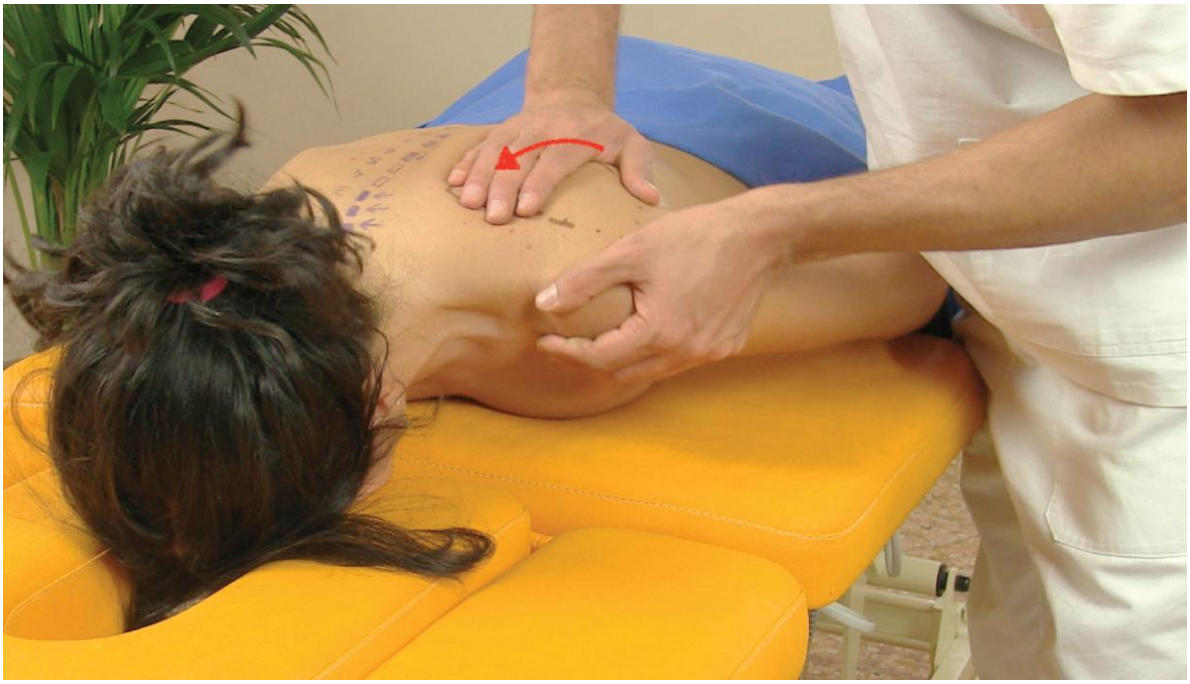
My approach to the shoulder considers and treats this group of joints as a **unique functional unit,** for this reason the manipulations I am going to teach will head to realign this functional unit in order to favor the healing of all the soft tissues composing it.

I guarantee that in most cases the method I am going to teach will let you succeed where the majority of your colleagues fail and I am very about this.

SHOULDER MANIPULATIONS

Scapulothoracic Manipulation

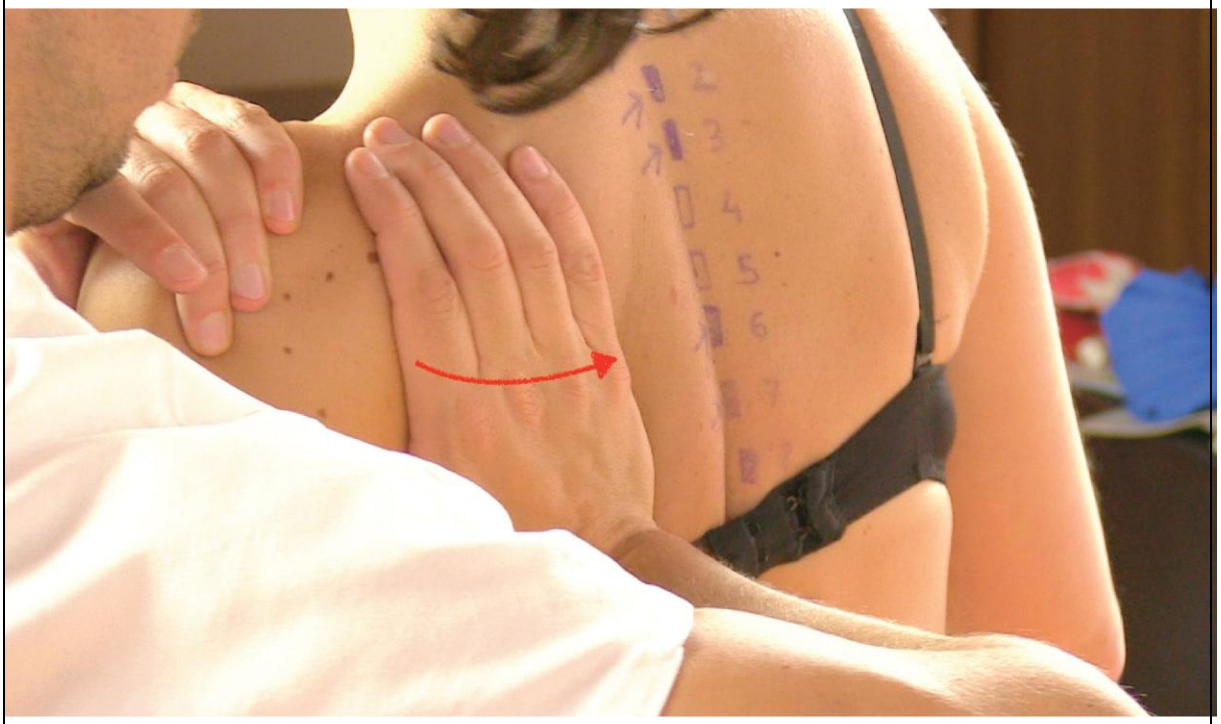
- Patient's position: prone
- Therapist's position: ipsilateral to the dysfunction
- Grab: one stability hand (positioned as a cup) under the shoulder and the other vertically positioned on the medial edge of the scapula.
- Test and scapulothoracic manipulation
- Post manipulative Test (functional)



Flexed elbow alternative (see video)

Scapulohumeral Manipulation

- Patient's position: seated
- Therapist's position: ipsilateral to the dysfunction
- Grab: one stability hand (positioned as a cup) under the shoulder and the other vertically positioned on the medial edge of the scapula.
- Test and Scapulohumeral manipulation
- Post manipulative Test (functional)

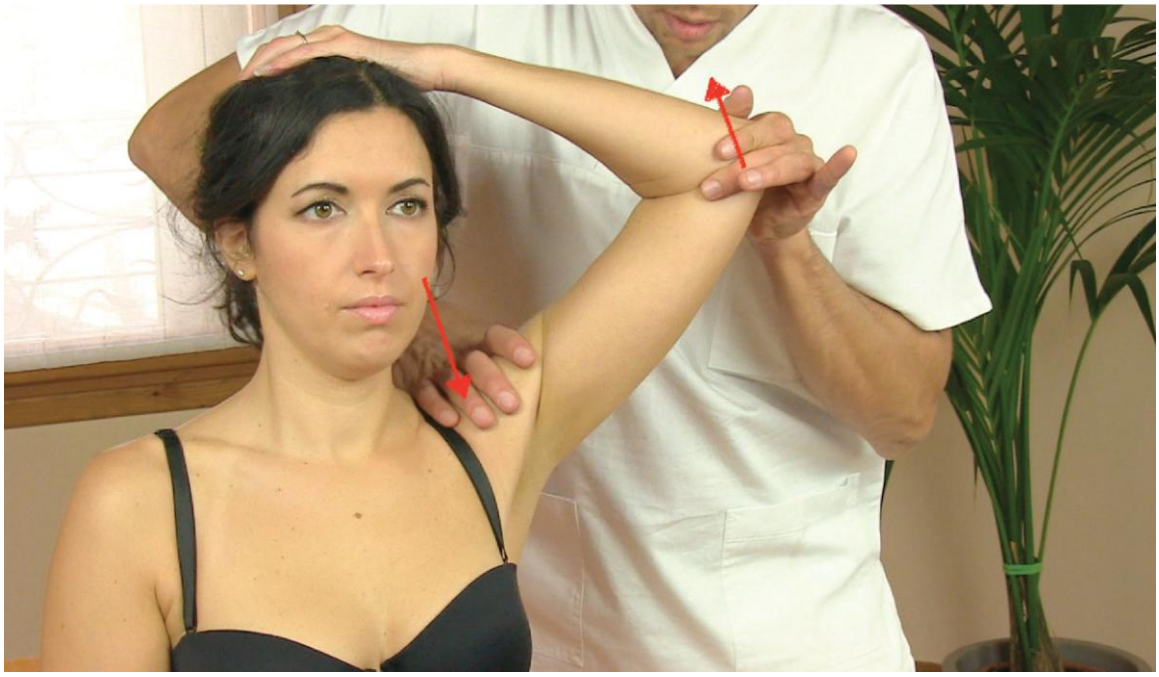


Standing alternative

- Patient's position: standing, with one hand on the hip
- Therapist's position: ipsilateral to the dysfunction
- Grab: one stability hand (positioned as a cup) under the shoulder and the other behind the elbow.
- Test and Scapulohumeral manipulation Post manipulative Test (functional)

Acromion-clavicular Manipulation

- Patient's position: seated with a hand on the head
- Therapist's position: behind the patient
- Grab: one stability hand and the other positioned on the acromion-clavicular joint and the other one in front of the elbow.
- Test and acromion-clavicular manipulation
- Post manipulative Test (functional)



Sternum-Clavicular Manipulation

- Patient's position: supine
- Therapist's position: alongside the patient, ipsilateral to the dysfunction
- Grab: the manipulating hand's pisiform on the sternum-clavicular joint, while the other hand stabilizes positioning on the opposite stump (crossed-grab)
- Test and sternum-clavicular manipulation
- Post manipulative Test (functional)

In order to be always effective in all the painful shoulder conditions that I listed, I suggest to always accompanying to this global treatment the thoracic and spinal manipulations I taught in the other course.

Conclusion and painful shoulder's treatment considerations

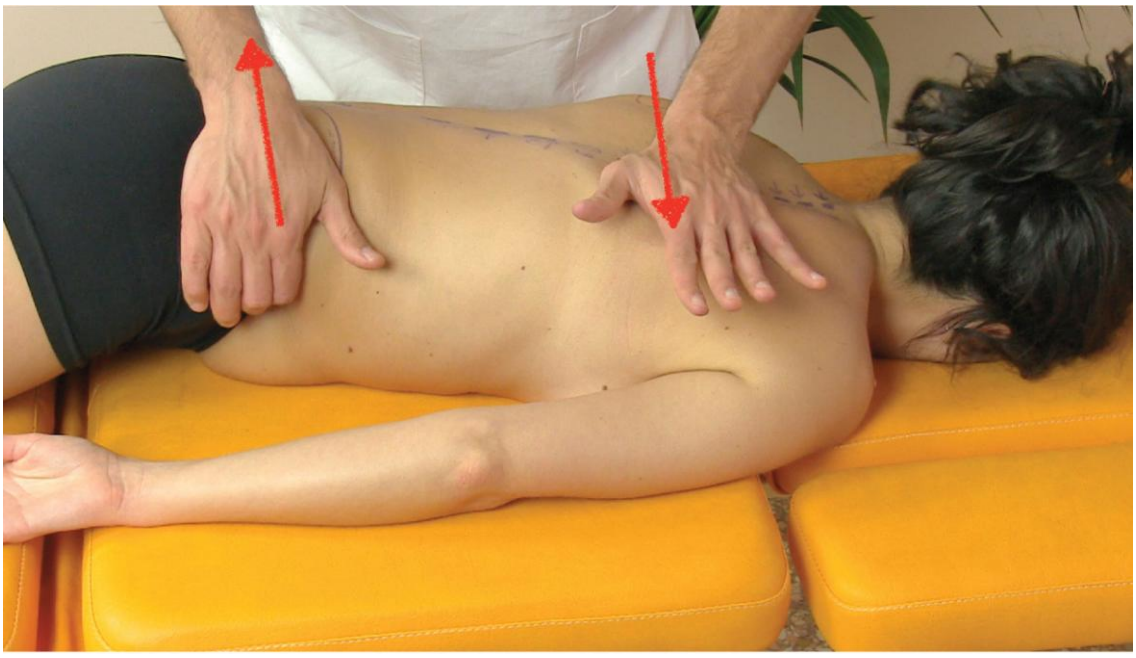
My advice is to consider and treat the shoulder as **a single functional unit** without reasoning clinically on every single muscle and function separately, as I erroneously used to do too.

What I just taught is the approach that let me solve successfully the cases of painful shoulder that otherwise would have required a surgical operation.

RIB CAGE MANIPULATIONS

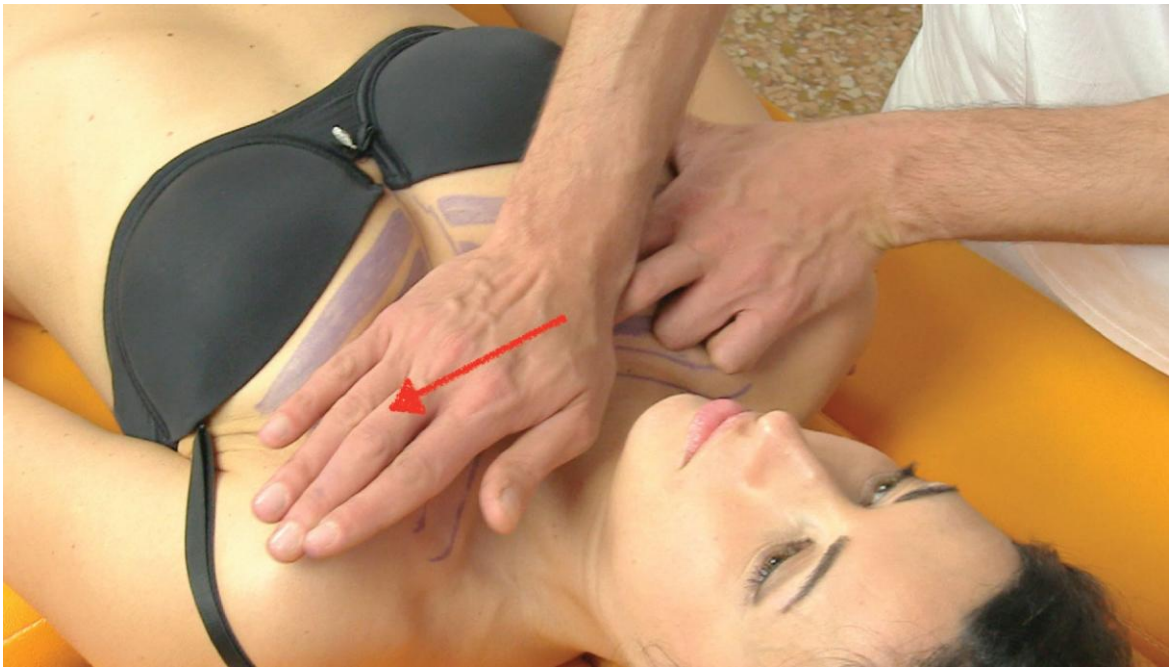
Rib Cage Manipulation

- Patient's position: prone
- Therapist's position: alongside the patient, contralateral to the dysfunction
- Grab: one hand on the anterior superior iliac spine on the other touching the first rib-spinal joints
- Test and Rib Cage Manipulation
- Post manipulative Test (palpation/mobility)



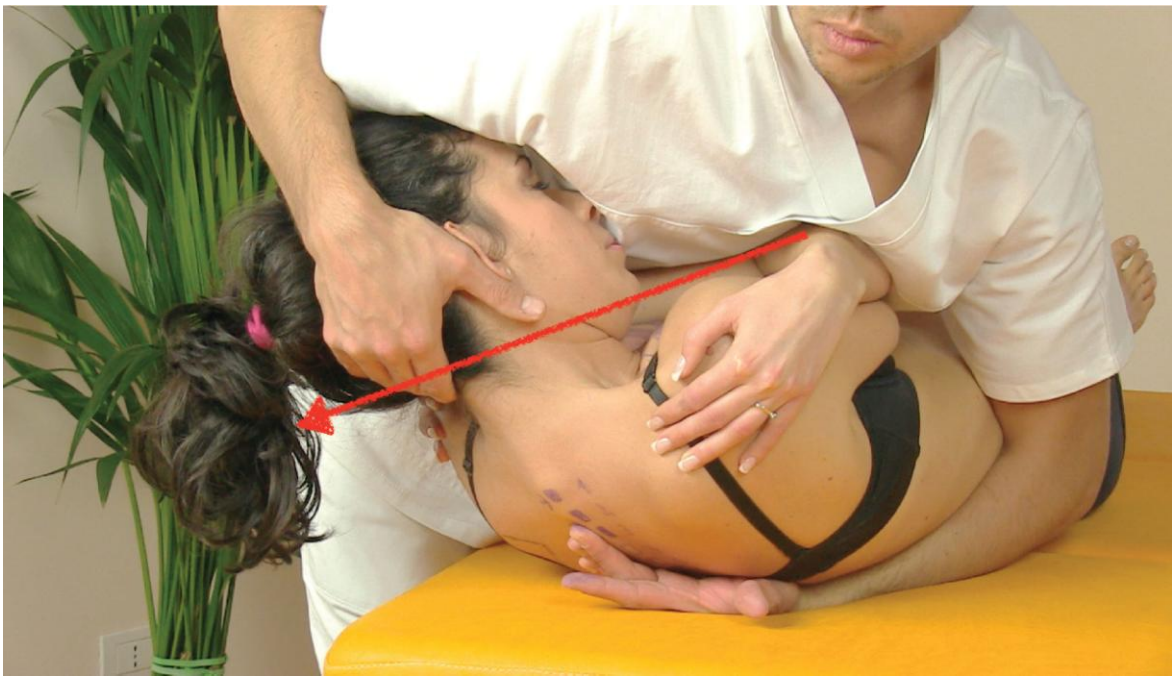
Anterior Ribs Manipulation (1-5)

- Patient's position: supine
- Therapist's position: alongside the patient, contralateral to the dysfunction
- Grab: one hand with index and middle finger between the rib to manipulate, the other hand positioned vertically through the pisiform or furrow pushes in oblique direction.
- Test and Anterior Ribs Manipulation
  Post manipulative Test (palpation/mobility)



Rib 6-7 Manipulation

- Patient's position: supine with crossed arms
- Therapist's position: in front of the patient, ipsilateral to the dysfunction
- Grab: one hand with the furrow between tenar and hypotenar positioned on the rib-spinal joint 6 and 7, the other hand under the nape of the neck of the patient brings it lateral to flexion towards the therapist.
- Test and Rib 6-7 Manipulation
  Post manipulative Test (palpation/mobility)



Rib 11-12 Manipulation

- Patient's position: seated with hands crossed behind the head.
- Therapist's position: behind the patient, ipsilateral to the dysfunction
- Grab: one hand grabs the patient's shoulder from behind, passing in front of patient's chest, the other hand in support with pisiform on the 11-12 rib-spinal joints
- Test and Rib 11-12 Manipulation
- Post manipulative Test (palpation/mobility)

ELBOW MANIPULATIONS AND EPICONDYLITIS/MEDIAL EPICONDYLITIS TREATMENT

I consider the elbow, such as the knee, as a “victim” in biomechanical terms, as it usually suffers the charges and the microtraumatisms because of the unbalances of the surrounding joints.

My advice then, is to treat all these joints close to the elbow (wrist, shoulder) with the manipulations I teach, accompanying them to these, specific for the elbow, that am going to teach and to the spinal ones in the other course, because in this way you will notice that you will be able to have always surprising results.

Humerus-radial Manipulation

- Patient's position: seated
- Therapist's position: alongside the patient, ipsilateral to the dysfunction
- Grab: one hand with the thumb touching the humerus-radial joint and the other on the distal part of the radius
- Test e Humerus-Radial manipulation
- Post Manipulative test (functional)
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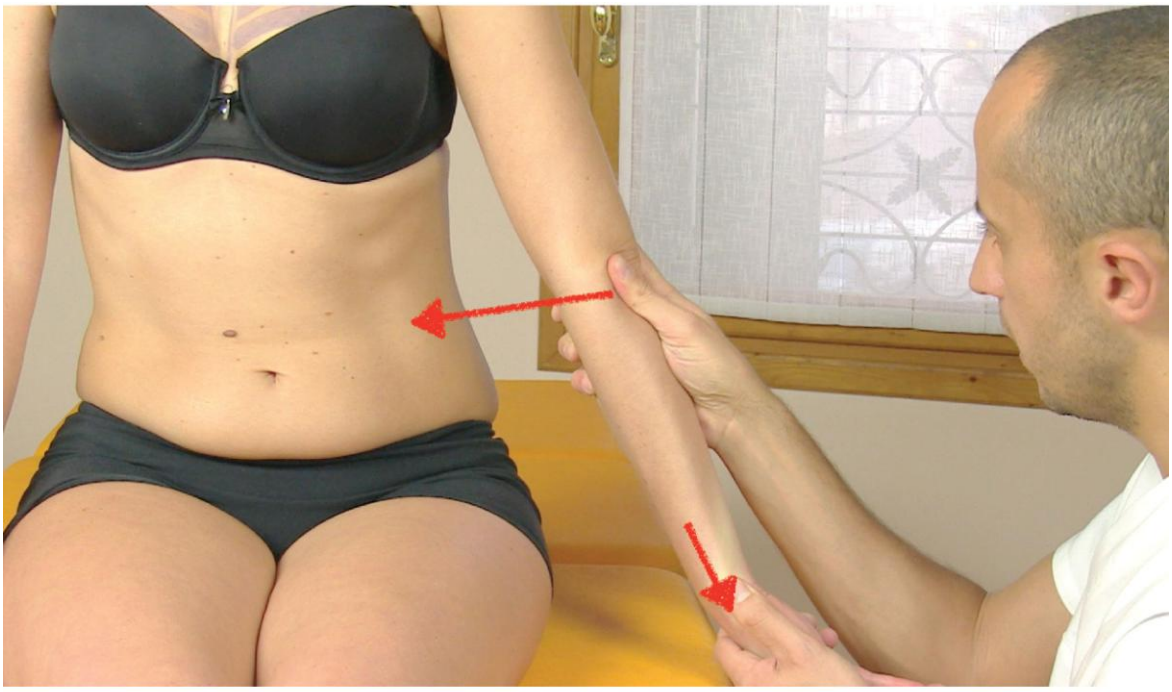


Humerus-Back Manipulation

(to be used just in case of elbow's extension insufficiency and the joint of the elbow is too painful to be manipulated)

- Patient's position: standing
- Therapist's position behind the patient, ipsilateral to the dysfunction
- Grab: Both hands wrapping the distal part of the patient's humerus from behind
- Test and Maniplation Humerus-Back
  Post Manipulative test (functional)

WRIST AND HAND MANIPULATIONS

(TREATMENT OF CARPAL TUNNEL SYNDROME TRATTAMENTO SINDROME DEL TUNNEL CARPALE E TENDINITE POLSO)

I wanted to include again the treatment of the carpal tunnel syndrome in paragraph because this syndrome, as I taught you in the spinal manipulations manual, is also defined “Double Crush Syndrome”.

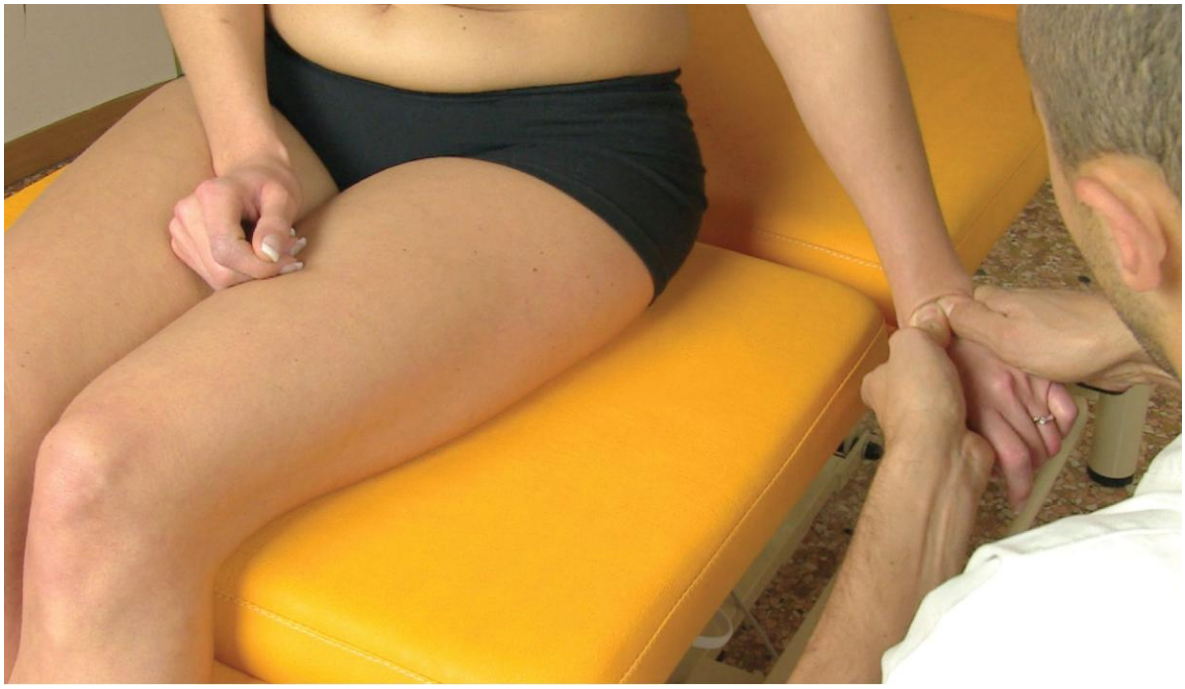
The first cause, which is clinically the most important, is due in my opinion to cervical dysfunctions, the other one is due to wrist and hand dysfunctions.

Performing the manipulations I will teach, we will normalize the dysfunctions that almost always exist both with the carpal tunnel syndrome and wrist tendinitis. You should know that the wrist dysfunctions moreover, are mainly the primary or secondary causes of epicondylitis and medial epicondylitis. My advice then is to normalize also the wrist’s and hand’s dysfunctions when painful elbow syndromes exist.

I’d like to spend a few words about rhizarthrosis because it can be treated during its non acute stages with the same global clinic reasoning that I taught until now, having great positive results.

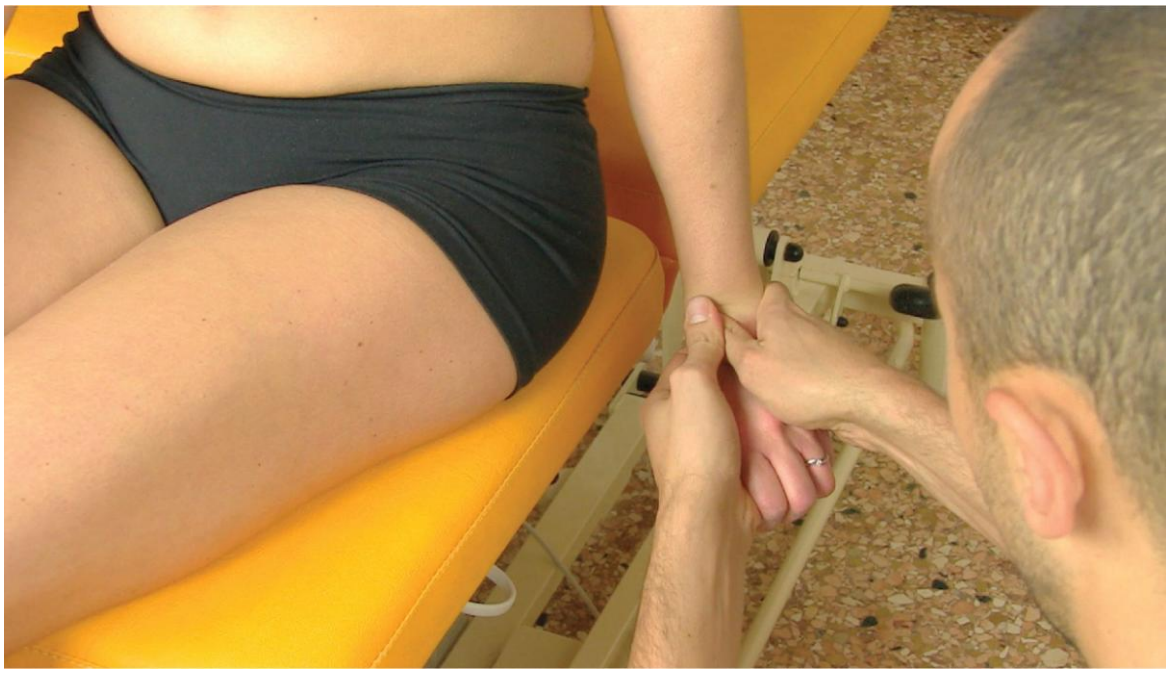
Semilunar Manipulation

- Patient's position: seated
- Therapist's position: alongside, ipsilateral to the dysfunction.
- Grab: a thumb positioned on the semilunar and the other overlapping (posterior-anterior push or reverse)
- Test and Semilunar Manipulation
  Post manipulative Test (functional)



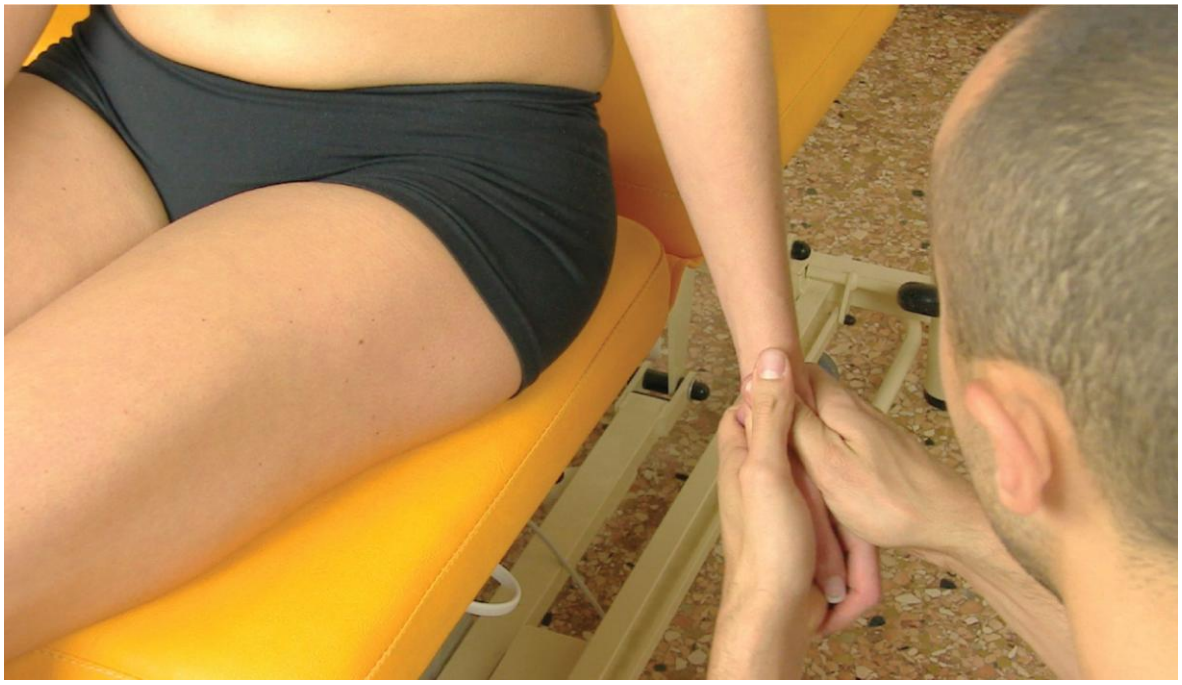
Distal Radius Manipulation

- Patient's position: seated
- Therapist's position: alongside, ipsilateral to the dysfunction.
- Grab: a thumb positioned on the semilunar and the other overlapping (posterior-anterior push or reverse)
- Test and Radius DistalManipulation
  Post manipulative Test (functional)



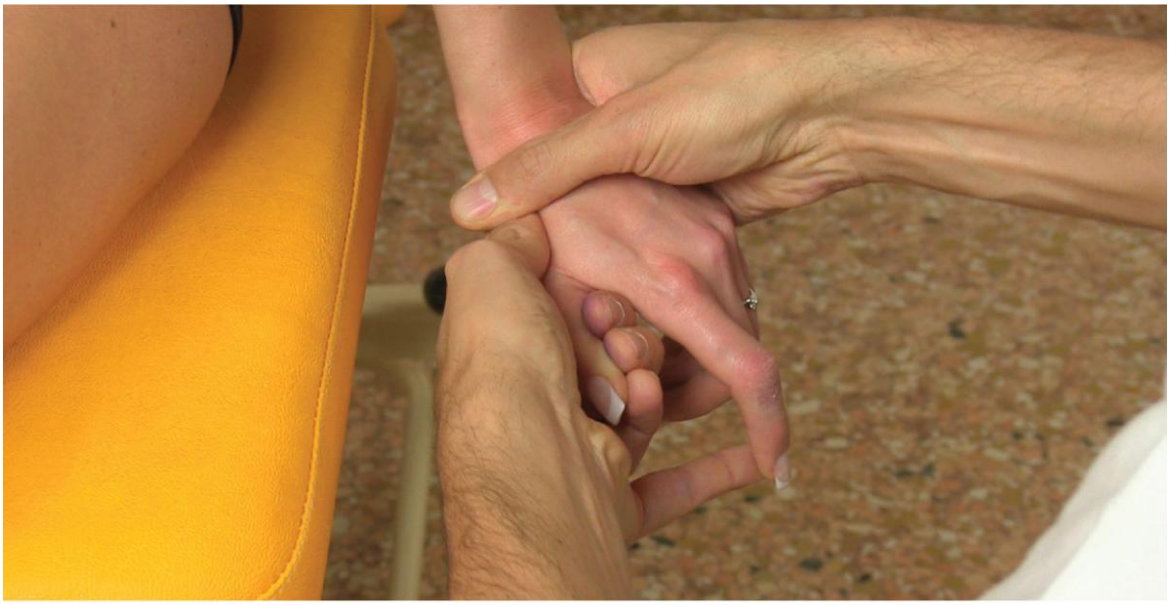
Radius and Distal Ulna Manipulation

- Patient's position: seated
- Therapist's position: alongside, ipsilateral to the dysfunction.
- Grab: a thumb positioned on the semilunar and the other overlapping (lateral-medial push)
- Test and Manipolazione Radius and Distal Ulna Manipulation
  Post manipulative Test (functional)



TRAPEZIUS-METACARPAL MANIPULATION
(1° Metacarpal)

- Patient's position: seated
- Therapist's position: alongside, ipsilateral to the dysfunction.
- Grab: one hand grabs the 1st Metacarpal, positioning the thumb of the same hand on the trapezius metacarpal joint, the other hand on the distal radius horizontally and once tensioned it goes to reinforce with the thumb the one in touch with the trapezius metacarpal joint.
- Test and Trapezius Metacarpal Manipulation
  Post manipulative Test (functional)

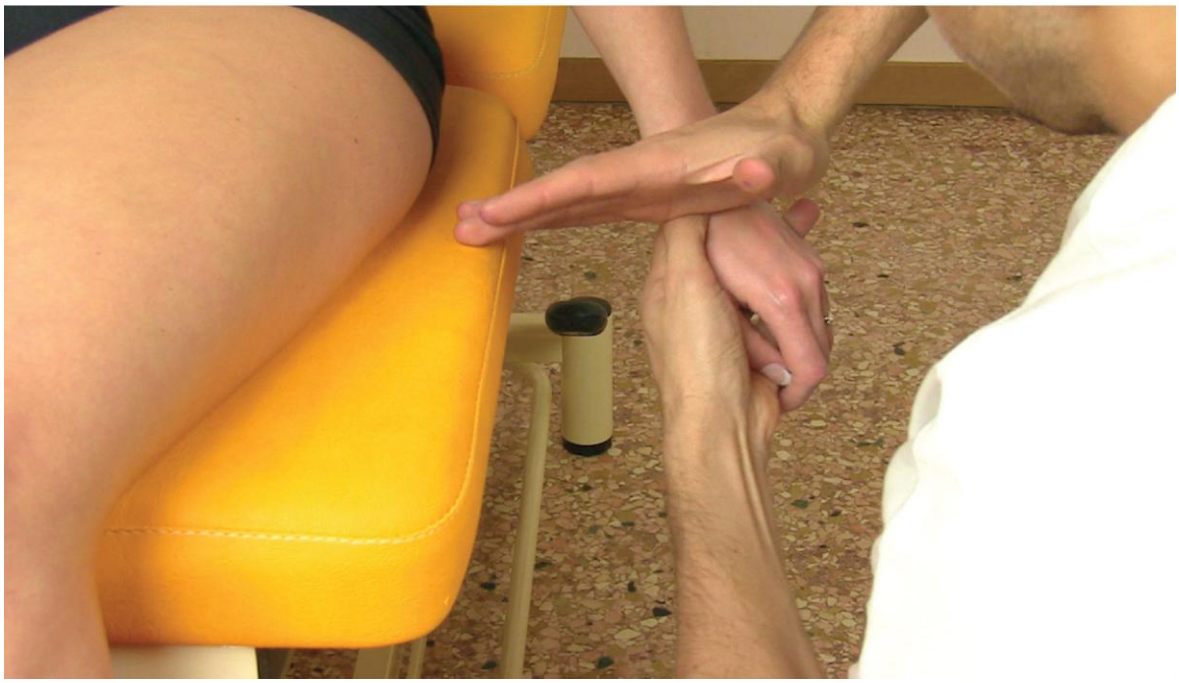


For an effective treatment of painful conditions such as epicondylitis and medial epicondylitis**, wrist tendinitis and carpal tunnel syndrome** I suggest to accompany the manipulations of the entire upper limb, the cervical and of the chest that you find in my course about spinal manipulations.

The reason is quite intuitive as at a biomechanical level all the joints that are functionally linked to the one suffering the most significant dysfunction tend to suffer dysfunctions too, having a bad influence if not properly treated.

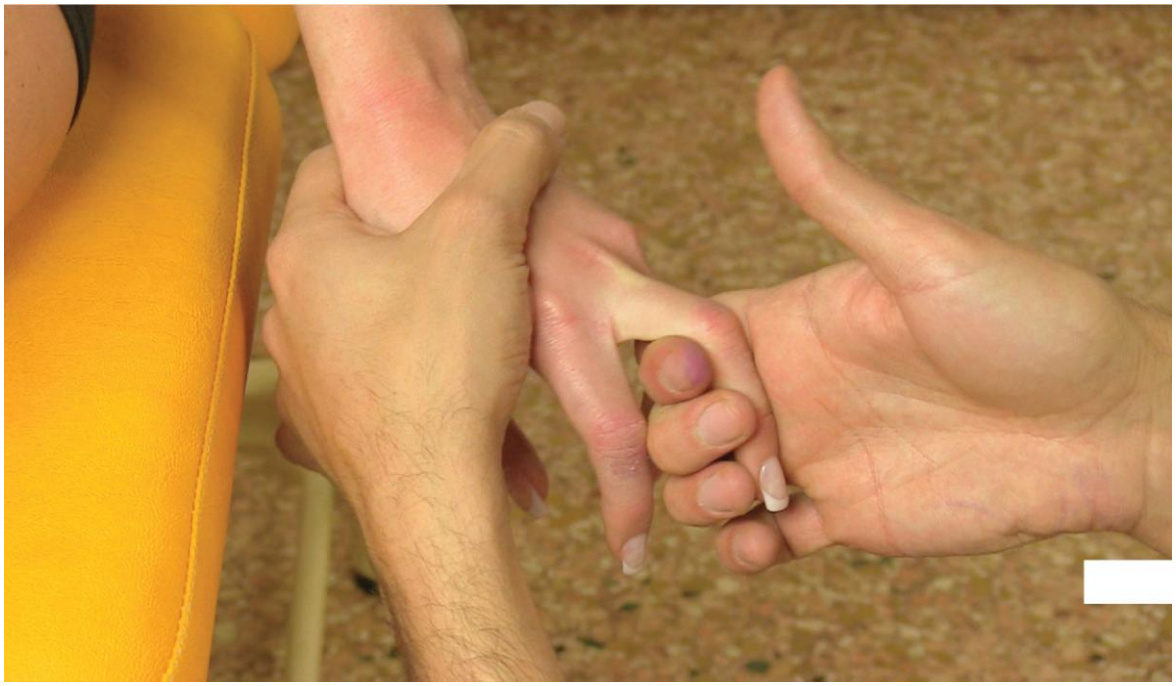
Scaphoid Manipulation

- Patient's position: seated
- Therapist's position: alongside, ipsilateral to the dysfunction.
- Grab: one thumb positioned on the scaphoid and the other hand overlapping the pisiform in touch.
- Test and Scaphoid Manipulation
  Post manipulative Test (functional)



Phalanges Manipulation

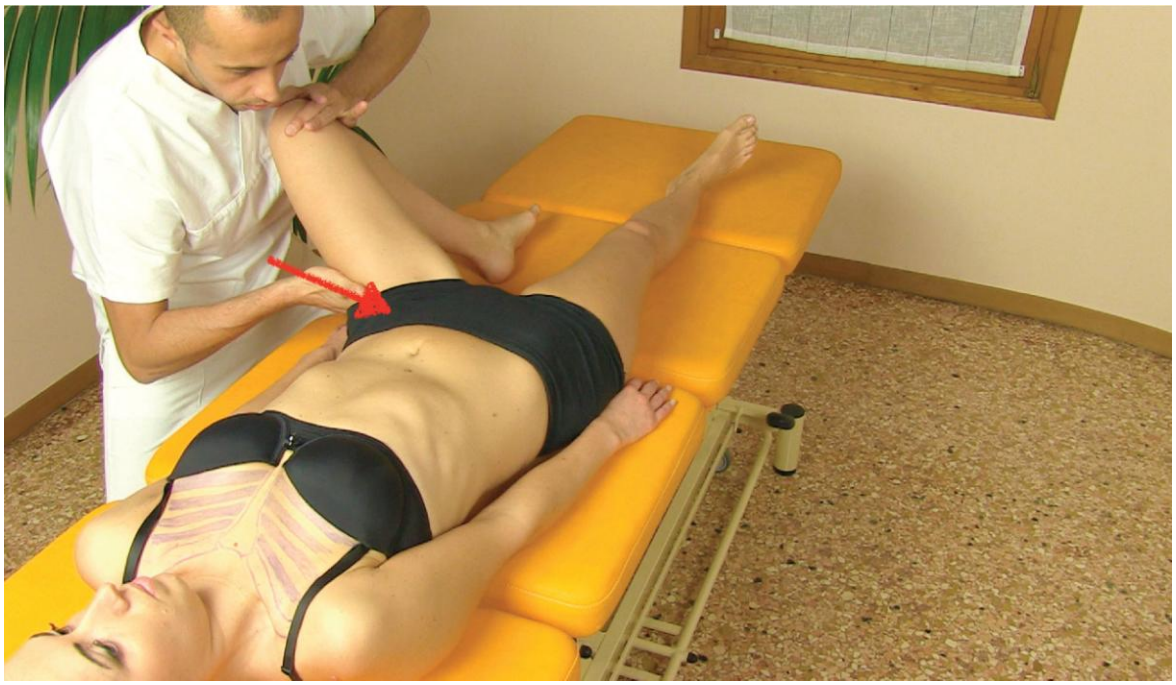
- Patient's position: seated
- Therapist's position: alongside, ipsilateral to the dysfunction
- Grab: one hand supports the patient's wrist while the other wraps the finger to manipulate.
- Test and Phalanges Maniplulation
  Post manipulative Test (visual, see nails' external/internal rotation)



HIP MANIPULATION

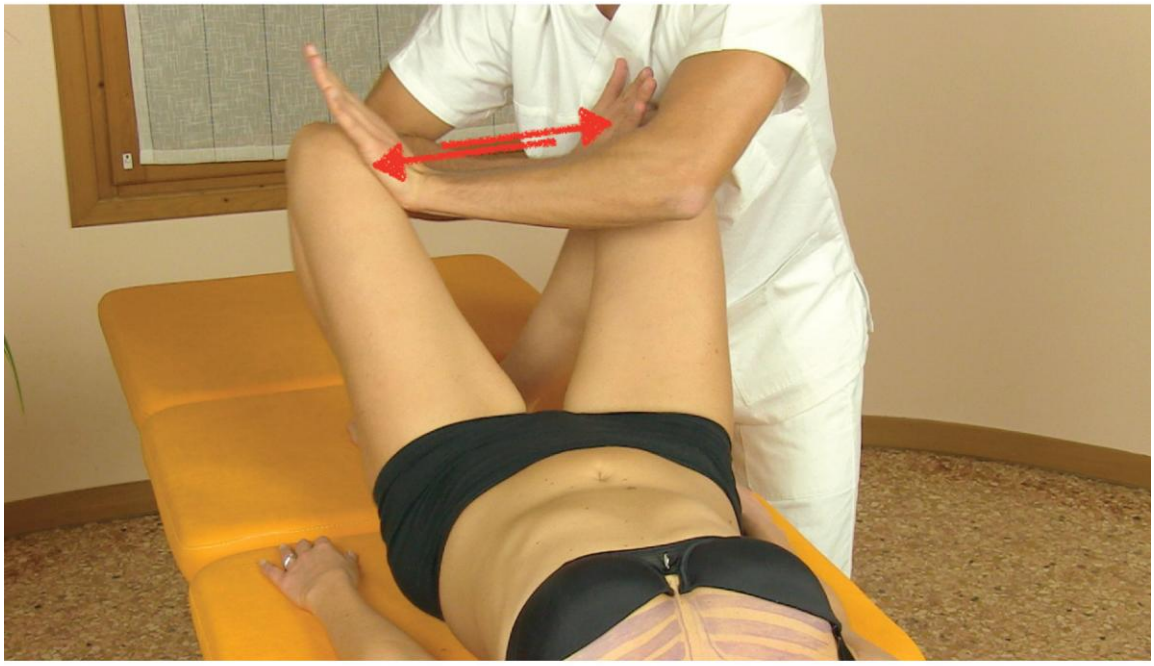
Femur Acetabular Manipulation

- Patient's position: supine
- Therapist's position: ipsilateral to the dysfunction
- Grab: one hand on the lateral and proximal part of the femur in the greater trochanter region and the other lying on the medial part of the knee.
- Test and Femur Acetabular Manipulation
- Post manipulative Test (functional,
  Test Post manipulative (functional, abduction/adduction)



Symphysis Pubis Manipulation

- Patient's position: supine, bent knees
- Therapist's position: alongside the patient
- Grab: the hands support the medial part of the patient's knees.
- Test and Symphysis Pubis Manipulation
  Post manipulative Test (functional, abduction/adduction)



KNEE MANIPULATIONS
MENISCOPATHY – GONALGIA TREATMENT, KNEE SPRAINS OUTCOMES

I consider the knee, such as the elbow, as a “victim” in biomechanical terms, in this case mainly because of the stresses received from the feet, the hip and the back.

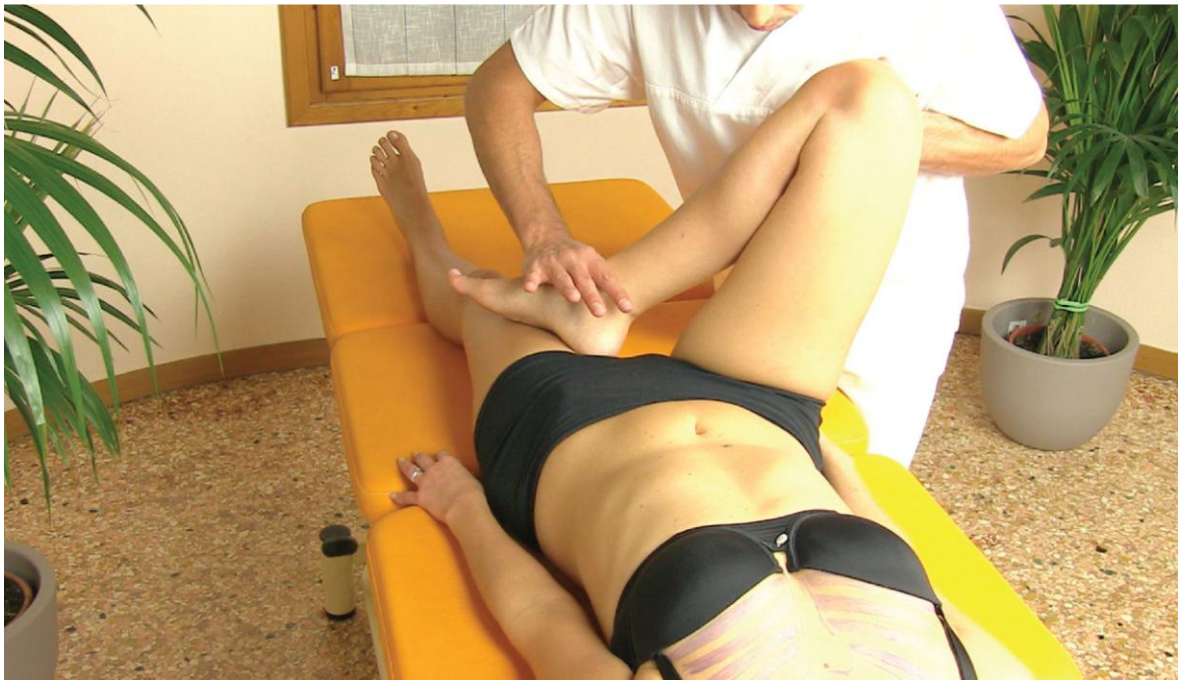
Following the approach that I taught in the spinal manipulations course you will notice the relief you can give also to a patient who suffers at first stage of a strong pain, inflammation or movements restriction by treating the back and the joints close to the knee.

Obviously now I am going to teach you the specific techniques aimed to the treatment of the knee dysfunctions, that I suggest to accompany to the global treatment, so to the spinal manipulations. Many of these manipulations, even if performed in single, so not accompanied to the global treatment, can give an instant relief and benefit is properly performed and if the main reason of the symptom is exactly the dysfunction of the treated peripheral joint.

Proximal Tibio-Peroneal Manipulation (anteriorization)

When we find a dysfunction where there is a tibio-peroneal proximal posteriority.

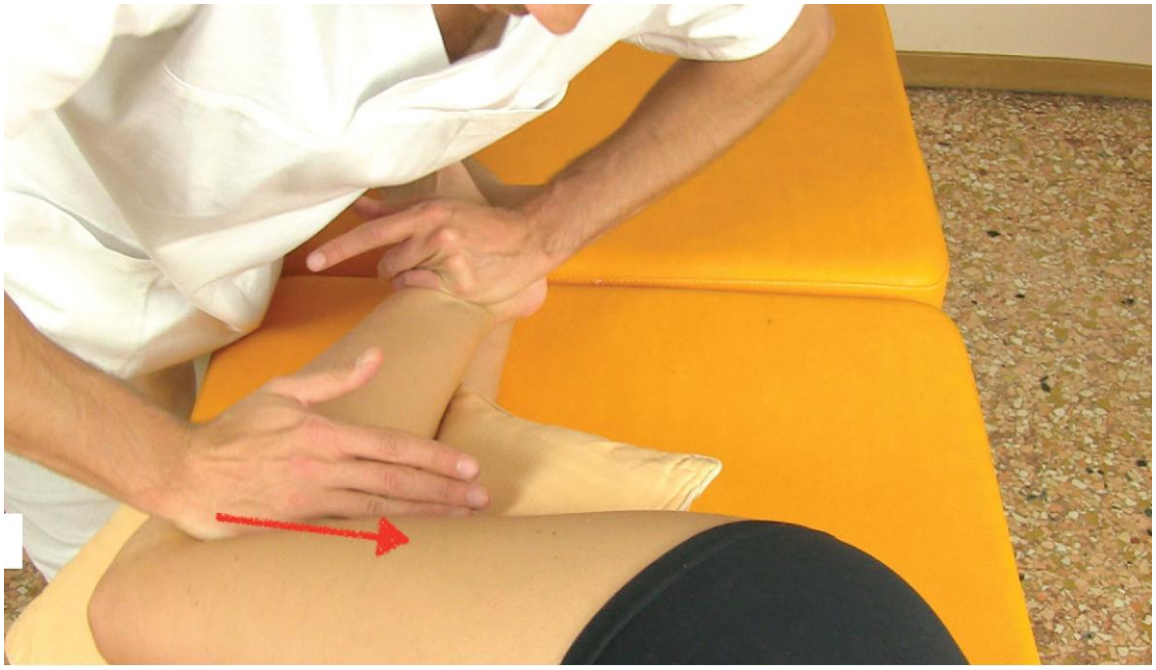
- Patient's position: supine
- Therapist's position: ipsilateral to the dysfunction
- Grab: one hand wraps the front of the ankle and the other with index and middle finger behind the head of fibula.
- Test and Tibio-Peroneal Manipualtion
  Post manipulative Test (functional)



Proximal Fibula Manipulation (posteriorization)

Targeting the superior head of fibula, so proximal at the back

- Patient's position: On the flank with a pillow between the legs, the dysfunctioned side up and knee bent at 90°.
- Therapist's position ipsilateral to the dysfunction and in from of the patient
- Grab: the pisiform of one hand in touch with the superior head of fibula and the other hand stabilizes the inferior part of the fibula.
- Test and Tibio-Peroneal Manipulation (proximal fibula posteriorization)
  Post manipulative Test (functional)



Tibia Manipulation (anteriorization)

If the tibia is posteriorized respect to the femur, this can happen after an impact from front to back.

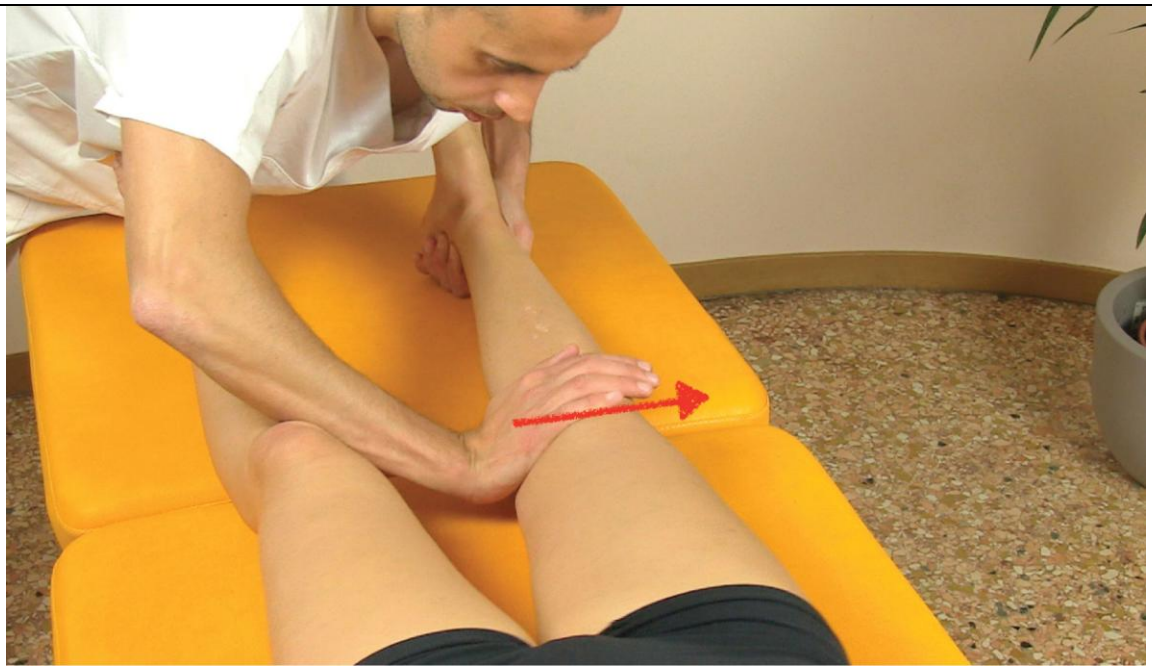
- Patient's position: prone
- Therapist's position: ipsilateral to the dysfunction
- Grab: both the hands join wrapping the proximal part of the tibia from the back.
- Test and Tibia Manipulation (anteriorization)
  Post manipulative Test (functional)

If the knee suffered a internal or external rotation in addition to a push from the front to the back, it is necessary to manipulate rotating first the tibia in the opposite sense.

So if the knee suffered a sprain in addition to the impact from the front to the back, it is necessary to rotate the tibia before the impulse in the opposite sense respect to the sprain.

Manipulations to reduce lateral and rotational misalignments

- Patient's position: supine
- Therapist's position: ipsilateral to the dysfunction
- Grab 1: one hand on the tibial malleolus and the other on the lateral side of the knee
- Grab 2: one hand on the peroneal malleolus and the other on the medial part of the knee.
- Test and Manipulation to reduce lateral and rotational misalignments
  Post manipulative Test (functional)



ANKLE AND FOOT MANIPULATIONS

(TREATMENT OF ANKLE SPRAINS OUTCOMES - METATARSALGIA PLANTAR FASCITIS)

The manipulations for the ankle and the foot that I am going to teach you will help to reduce the dysfunctions that occur and often are the cause of ankle sprains metatarsalgia and plantar fasciitis

You can always perform all the manipulations that I teach you as a global approach routine

As id do, accompanying them to the treatment for every problem of the lower limb, where the ankle and the foot are involved for sure.

Tibia-Talus Manipulation

- Patient's position: supine
- Therapist's position: ipsilateral to dysfunction
- Grab: both hands grab the tibia-talus joint pushing mainly with middle and ring finger
- Test and Tibio-Talus Manipulation
  Post manipulative test (functional)

1st Metatarsal Manipulation

- Patient's position: supine, knee bents and rotating to internal
- Therapist's position: ipsilateral to dysfunction
- Grab: one hand's thenar positioned on the 1st metatarsal while the other, overlapped, works as a support.
- Test and 1st Metatarsal Manipulation
  Post manipulative test (functional)

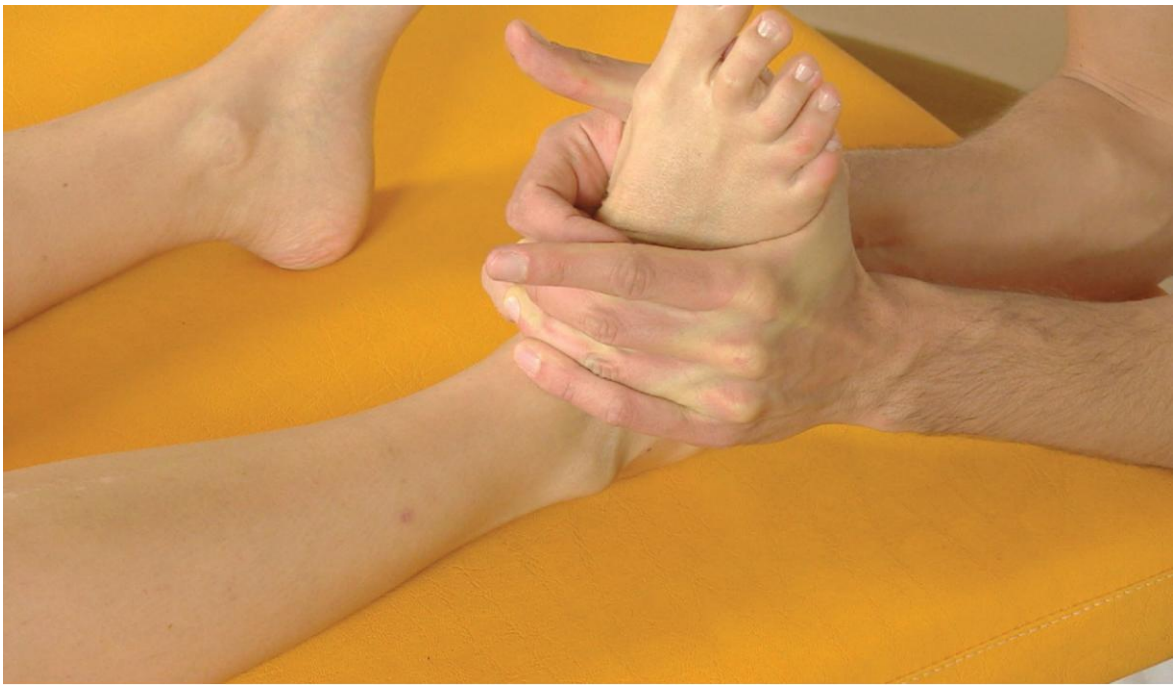
1st and 2nd Cuneiform Manipulation

- Patient's position: supine
- Therapist's position: ipsilateral to dysfunction
- Grab: both hands grab 1st and 2nd cuneiform pushing mainly with middle and ring finger
- Test and 1st and 2nd cuneiform Manipulation
  Post manipulative test (functional)

1st and 2nd cuneiform Manipulation (similar to Tibia-talus but without eversion)

5th Metatarsal Manipulation (externally rotated)

- Patient's position: supine
- Therapist's position: ipsilateral to dysfunction
- Grab: one hand wraps the foot in touch with the 5th metatarsal and the other supports from the inner side
- Test and 5th Metatarsal Manipulation
  Post manipulative test (functional)

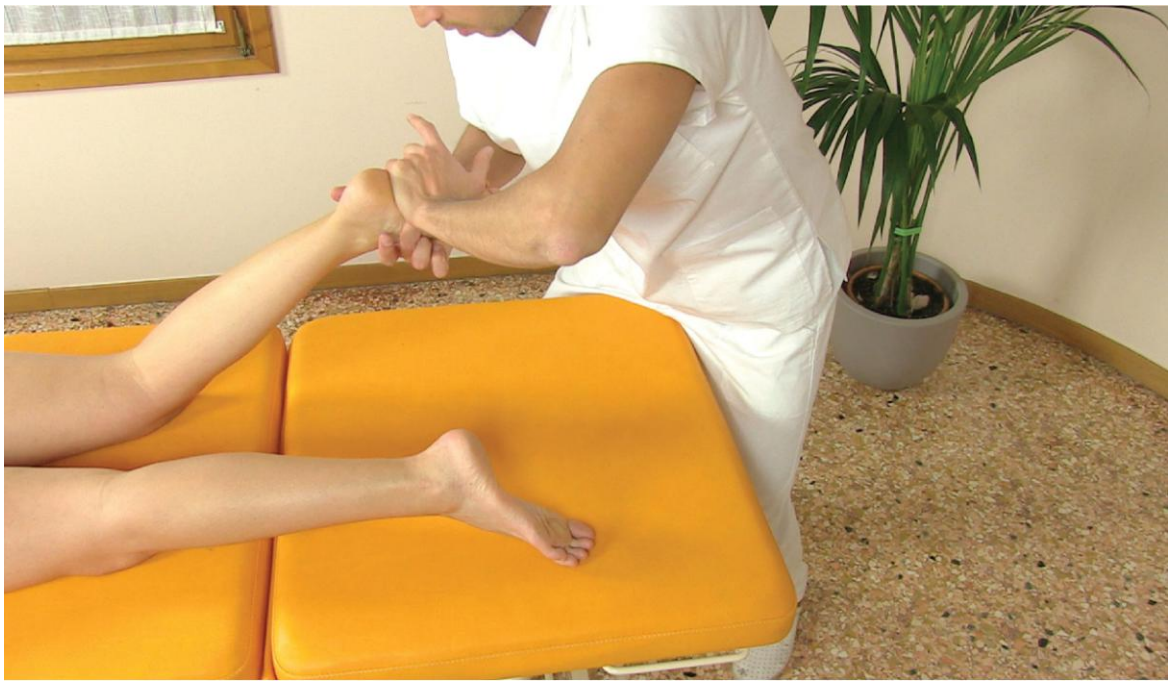


Cuboid Manipulation

- Patient's position: supine
- Therapist's position: ipsilateral to dysfunction
- Grab: one hand wraps the medial part of the forefoot and stabilizes; the other hand is in touch with the cuboid alongside with the thenar.
- Test and Cuboid Manipulation
  Post manipulative test (functional)

Navicular Manipulation

- Patient's position: prone
- Therapist's position: ipsilateral to dysfunction
- Grab: the right hand (if the foot is the right one, or vice versa) wraps the back of the foot and grabs the navicular with the middle finger, the pisiform of the other hand overlaps the middle finger of the other hand as a support
- Test and Navicular Manipulation
  Post manipulative test (functional)



1st 2nd 3rd 4th and 5th Finger Manipulation

- Patient's position: supine
- Therapist's position: ipsilateral to dysfunction
- Grab: one hand grabs a finger between the thumb and index finger, the other hand overlaps as a support
- Test and 1st 2nd 3rd 4th and 5th Finger Manipulation
  Post manipulative test (functional)

CONCLUSIONS

Congratulations for deciding to learn my peripheral manipulations techniques, I wish and I am sure that my teachings will let you make the difference.

The main scope of this course is to make your professional life and your patients' health better.

I suggest you to integrate the manipulations you just learned with the spinal manipulations that you learned in the previous course. In this way you will be able to offer to your patients global complete treatments and for sure you will have an extra gear in the treatment of several musculoskeletal painful conditions.

I wish you a great success as a professional and I am very happy to contribute to your professional skills.

I wish you to do a good job!

Marco Aruffo

Disclaimer

This course provides an overview of nutrition in physiotherapy as a whole. In no way wants to replace the opinion of the doctor who remains the primary reference for every disease and disorder of the patient. On the basis of this "Marco Aruffo declines all responsibility in relation to the contents of the Physiotherapy and Nutrition course", and refers to the subject who takes advantage of the course itself, compliance with the laws in force in this matter. For some photos we refer to the free photos available on Google images and for the others the reference links have been listed. All course information should not be used as a substitute for medical advice, professional assessment and / or medical treatment, as it is generic information and not personalized information. Please note that the diagnosis of diseases and dysfunctions is purely medical competence.

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