Pain MANAGEMENT

SPECIAL INTEREST GROUP • ORTHOPAEDIC SECTION, APTA, INC.

Letter from the President

Joseph A. Kleinkort, PT, MA, PhD, CIE

This is a very rare and exciting time in the field of pain management. At the same time there are 3 new and dramatically different and somehow very similar techniques emerging in the physical therapy realm. The first two are mainly a series of techniques applied manually and the third is a new modality.

I just returned from a course that I must recommend to anyone who is interested in changing patterns of chronicity in a rather immediate fashion. The work is called PRRT and is a remarkable new way to release neuromuscular patterns that have been engrained in the system for a long time. The work is very easy to learn and extremely refreshing in its results without having to go through years of complex training. John Iams' paper in the last edition of *OP* can enlighten you further as to the method of this approach. I highly recommend this work. The results are nothing short of immediate and amazing.

Another equally dramatic technique emerging is that of Alan Weismantal's 'Functional Mobilization.' The article to follow will give you some of the background to this technique. These manual techniques can dramatically alter pathology whether acute or chronic. He incorporates various manual methods to include aspects of myofascial, neural, visceral, and articular mobilization.

Finally, I must touch on the final breakthrough in new technology coming out in the area of light therapy. While some of the light products are arrays of light, one of them (Erchonia) is a true laser with the ability to modulate up to 4 frequencies. This ability to alter frequencies has a dramatic effect on the ability to reset the muscle. The use of frequencies actually goes back to the 1920s and has been used recently very successfully in small groups with microcurrent, but not on a wide scale. Now that more has come out in the area of biological coherence from Herbert Frohlich's work, we can see how important the resonance of the living matrix truly is. Its function in the area of neuromuscular re-education will be a tremendous tool for the clinician in the future.

These are very exciting times in the area of rehabilitation. It is more important now than ever that we continue our education and constantly keep our minds open to new thoughts, ideas, and concepts. These are truly changing times and those with set paradigms who are unable to shift their thinking will be left in the dust of new and dramatically more effective techniques and technology. What is most interesting is that much of this draws on knowledge that we have already known but had not synthesized in a coherent and user friendly pattern. Again I urge you to send short articles you would like printed in the newsletter that have to do with pain management. I look forward to seeing each of you at our Annual Conference in Washington, D.C.

Functional Mobilization

Alan Weismantel, PT, OMT, FAAOMPT

This is a brief overview of a new series of manual techniques that I have used and have come to call Functional Mobilization. The treatment technique is a combination of a variety of myofascial, neural, visceral, and articular mobilization techniques. The clinician uses these various tests and techniques to assess the patient's movement dysfunction. The difference with this and many other forms of manual work is that the clinician places their hands on the restricted tissues while the patient moves through a variety of functional movements. The patient is more actively involved in the accomplishment of the these techniques. Recoil methods also are used to further enhance the effectiveness of the treatment.

This work has evolved over 30 years of manual therapy training. In 1969 while performing nerve conduction velocity exams with EMG, I noticed that people with intense pain exhibited a minimum increase in distal latency while showing a proximal slowing of nerve conduction with decreased amplitude. In theory, this should have been the opposite. This sparked my interest in what Michael Rogers coined "the central peripheral connection." This made the idea that distal pain being caused by proximal structures was both intriguing and plausible.

Most of the techniques acquired in the 1970s to mid 1980s were active participation by the therapist and passive patient participation. Mobilization, myofascial release, and counterstrain were some of the techniques of concentration.

In 1989, I began extensive work with John Upledger and was exposed to visceral manipulation. A realization of the