



**The Secretary-General**

Michael Kuchera, D.O., FAAO

Marian University • 3200 Cold Spring Road • Indianapolis, Indiana 46222 • USA

email: [mkuchera@marian.edu](mailto:mkuchera@marian.edu)

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## **FIMM NEWS**

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**Volume 23**

**September 2016**

**No. 1**

special Conference edition  
v2

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Fédération Internationale de Médecine Manuelle  
International Federation for Manual/Musculoskeletal Medicine  
Internationale Gesellschaft für Manuelle Medizin

In conjunction with the  
Bulgarian Society of  
Manual Medicine BSMM

Final Announcement

## **16<sup>th</sup> FIMM International Scientific Conference 2016**

In conjunction with the Bulgarian Society of Manual Medicine

Medical University of Varna – Faculty of Medicine – Bulgaria

16<sup>th</sup> International Scientific Conference: September 17, 2016

2<sup>nd</sup> International Instructor Course: September 18-19, 2016

1<sup>st</sup> International Course in Manual/Musculoskeletal Medicine:  
September 18-19, 2016

## **More Science – Less Pain**

Hosted by the International Federation for Manual / Musculoskeletal Medicine FIMM

In conjunction with the Bulgarian Society of Manual Medicine BSMM

Organizer: International Federation for Manual/Musculoskeletal Medicine FIMM  
In conjunction with the Bulgarian Society of Manual Medicine BSMM

More Information: [www.fimm-online.com](http://www.fimm-online.com)

**President**

Simon Vulfsons

[s\\_vulfsons@rambam.health.gov.il](mailto:s_vulfsons@rambam.health.gov.il)

**Treasurer**

Aharon Finestone

[asff@inter.net.il](mailto:asff@inter.net.il)

**Co-Chairmen of the Scientific Conference Committee**

Iliya Todorov, [ilkotodorov@gmail.com](mailto:ilkotodorov@gmail.com)

Simon Vulfsons, [s\\_vulfsons@rambam.health.gov.il](mailto:s_vulfsons@rambam.health.gov.il)

**Scientific Conference Committee**

Michael L. Kuchera, [mkuchera@marian.edu](mailto:mkuchera@marian.edu)

Sergei Nikonov, Chairman, [snn00@list.ru](mailto:snn00@list.ru)

Bernard Terrier, [b.terrier@bluewin.ch](mailto:b.terrier@bluewin.ch)

Wolfgang von Heymann, [heymann@cosit.de](mailto:heymann@cosit.de)

### Who should attend

Musculoskeletal Specialists  
Physical Medicine and Rehabilitation Physicians  
General Practitioners interested in Manual and Musculoskeletal Medicine  
Orthopaedic Medicine Specialists  
Rheumatologists

### Conference Location

MEDICAL UNIVERSITY OF VARNA  
Faculty of Medicine  
55 Marin Drinov, Str.  
BG-9000 VARNA, Bulgaria  
Tel: +359 (52) 677 008 / Fax: +359 (52) 650 019  
e-mail: radevr@gmail.com  
www.mu-varna.bg/en

### Conference Language

The official language of the SCIENTIFIC CONFERENCE, the INTERNATIONAL INSTRUCTOR COURSE and the INTERNATIONAL COURSE IN MANUAL/MUSCULOSKELETAL MEDICINE is English.

### Local Conference Organizer

Bulgarian Society of Manual Medicine BSMM  
Boul. Zar Oswoboditel 70  
BG-9002 VARNA Bulgaria  
ilkotodorov@gmail.com  
phone: +359 89 8654 365

### Conference Structure

The Conference scientific programme will include plenary sessions in addition to special interest workshops. The program will feature international Manual Medicine clinicians and researchers.

### Scientific Committee

Dr. Ilya Todorov (Co-Chairman)  
Dr. Simon Vulfsons (Co-Chairman)  
Prof. Michael L. Kuchera  
Prof. Sergei Nikonov  
Dr. Bernard Terrier  
Dr. Wolfgang von Heymann

### Conference outline

	Thursday 15.09.2016	Friday 16.09.2016	Saturday 17.09.2016	Sunday 18.09.2016	Monday 19.09.2016
09:00	FIMM Executive Board Meeting	FIMM General Assembly 2016	FIMM and Bulgarian Society Conjoint Scientific Conference	International Instructor Course International Course in Manual/ Musculoskeletal Medicine Part I	International Instructor Course International Course in Manual/ Musculoskeletal Medicine Part III
09:30					
10:00					
10:30					
11:00					
11:30					
12:00					
12:30					
14:00	FIMM Executive Board Meeting	FIMM General Assembly 2016	Workshops	International Instructor Course International Course in Manual/ Musculoskeletal Medicine Part II	International Instructor Course International Course in Manual/ Musculoskeletal Medicine Part IV
14:30					
15:00					
15:30					
16:00					
16:30					
17:00					
17:30					
18:00					
20:00	Welcome Party	FIMM Dinner	Varna Event		

## Final Program

Saturday, September 17, 2016		
08:00 – 08:45	Registration and coffee	
08:45 – 09:00	Welcome Greetings Prof. Dr. Krasimir Ivanov, Rector of the Medical University of Varna Dr. Todor Todorov, President of the Bulgarian Society of Manual Medicine BSMM, Bulgaria Dr. Simon Vulfsons, President of the International Federation of Manual Medicine FIMM, Israel	
09:00 – 09:30	Wolfgang von Heymann: <i>Headache – Recent research results.</i>	
09:30 – 10:00	Michael L. Kuchera: <i>Research perspectives: Cervical palpatory diagnosis and treatment.</i>	
10:00 – 10:30	Daphne C. Rohrich: <i>Physicians specialized in spinal manipulative treatment in the Netherlands – A description of their characteristics and patients.</i>	
10:30 – 11:00	Coffee breake	
11:00 – 11:20	Marc-Henri Gauchat: <i>Pitfalls in Manual Medicine.</i>	
11:20 – 11:40	Nadezhda A. Krasnoyarova: <i>Osteopathic and manual correction of biomechanical disorders as a rational method of elimination of pain syndromes.</i>	
11:40 – 12:00	Simon Vulfsons: <i>CRPS and surprising reactivity to dry needling.</i>	
12:00 – 12:20	Ilya Todorov: <i>The sacroiliac joint dysfunction - clinical findings and manual therapeutic approach.</i>	
12:20 – 12:40	Negev Bar: <i>Manual Medicine – and the community.</i>	
12:40 – 13:00	Marc Henri Gauchat: <i>Radiological evaluation of the cervical spine in practice.</i>	
13:00 – 14:00	Lunch	
14:00 – 18:00	PARALLEL WORKSHOPS	
	WORKSHOP A Simon Vulfsons and Aharon Finestone <i>Introduction to myofascial pain and dry needling.</i>	WORKSHOP B Wolfgang von Heymann and Michael L. Kuchera <i>Examination of the cervical spine.</i> <i>Cervical manual treatment approaches.</i>
09:00 – 18:00	POSTER SESSION	
Sunday, September 18, 2016		
09:00 – 12:30	<b>INTERNATIONAL INSTRUCTOR COURSE</b> for teachers and practitioners in Manual and Musculoskeletal Medicine: <b>Part I.</b> <i>Neurophysiological approach to manual medicine / Validated diagnostic procedures: scientific references – What do we believe, what is proved? / Workshop on cervical diagnostic procedures with clinical examples</i> <b>INTERNATIONAL COURSE IN MANUAL/MUSCULOSKELETAL MEDICINE</b> The 20 Best Muscles <i>Assessment and Treatment of Myofascial Pain with Dry Needling (Intramuscular Stimulation) in conjunction with Manual Medicine components</i> <b>Part I: Dry needling technique / Head and Neck Pain / Forearm Pain</b>	
14:00 – 18:00	<b>INTERNATIONAL INSTRUCTOR COURSE</b> for teachers and practitioners in Manual and Musculoskeletal Medicine: <b>Part II.</b> <i>Introduction to the myofascial pain syndrome / Cervical therapy workshop</i> <b>INTERNATIONAL COURSE IN MANUAL/MUSCULOSKELETAL MEDICINE</b> The 20 Best Muscles <b>Part II: Shoulder Pain</b>	
Monday, September 19, 2016		
09:00 – 12:30	<b>INTERNATIONAL INSTRUCTOR COURSE</b> for teachers and practitioners in Manual and Musculoskeletal Medicine: <b>Part III.</b> <i>Workshop on thoracic diagnostic procedures with clinical examples / Thoracic therapy workshop</i> <b>INTERNATIONAL COURSE IN MANUAL/MUSCULOSKELETAL MEDICINE</b> The 20 Best Muscles <b>Part III: Hip and Low back Pain / Back Pain</b>	
14:00 – 18:00	<b>INTERNATIONAL INSTRUCTOR COURSE</b> for teachers and practitioners in Manual and Musculoskeletal Medicine: <b>Part IV.</b> <i>Workshop on lumbar diagnostic procedures with clinical examples / Workshop on lumbar diagnostic procedures with clinical examples / Workshop on sacro-iliac joint diagnostic procedures with clinical examples / Sacro-iliac joint therapy workshop</i> <b>INTERNATIONAL COURSE IN MANUAL/MUSCULOSKELETAL MEDICINE</b> The 20 Best Muscles <b>Part IV: Thigh and Knee Pain / Calf and Foot Pain</b>	
		2 ECTS both

## Abstracts

In alphabetical order

As a Federation of Manual Medicine societies, FIMM does not specifically endorse any research or perspective. It recognizes that research should be judged on the merit of its scientific findings rather than on the basis of the philosophy, school or professional degrees associated with the investigators involved. In this spirit, all abstracts and presentations associated with the FIMM Scientific Conference are offered within our Manual Medicine community to provoke discussion and to offer potential insights for others. It is hoped that these abstracts, their presentation, and any subsequent discussions or applications will foster further scientific inquiry and be of interest to physicians in our member's societies as well as to the Manual Medicine community generally.

With this in mind and in the interest of our conference theme, "More Science – Less Pain", FIMM offers the following:

### A. Presentations

Bar Negev – Israel – [negevbar@gmail.com](mailto:negevbar@gmail.com)

#### ***Manual Medicine - and the community. Prevalence of myofascial pain syndrome in primary, secondary and tertiary care - a cohort base study.***

##### *Introduction:*

Pain is a frequent reason to seek medical help in all levels of care. Myofascial pain (MFP) is a common etiology of pain. In this study, we documented the prevalence of MFP in primary, secondary and tertiary care by cohort-based studies

##### *Methods:*

The data in this presentation were collected in four cohort studies in the three levels of care:

Primary care: A cohort of all patients coming to their family physician with a complaint of pain (excluding cancer pain), during 6 months, in a rural clinic in the north of Israel (127 patients).

Secondary care: Two cohorts of all patients referred by their family physicians to a community-based pain consultation, in two different locations: Yokneam, a small town in the north of Israel (95 patients), and in Montreal, Canada (63 patients).

Tertiary care: A cohort of all patients seen in chronic pain center during a one year fellowship in a tertiary hospital in Montreal, Canada (127 patients).

##### *Results:*

412 patients were enrolled in the four cohorts. The prevalence of MFP was 92%, 73-75% and 63% in primary, secondary and tertiary care respectively. The lower back was the most common site of pain, at all levels, with 27-53% of the MFP. 13% of the patients in primary care had chronic pain. 41-43% of the patients in secondary care had chronic pain. In addition, as expected, 99% of the patients seen in the tertiary chronic pain center had chronic pain.

##### *Conclusions:*

MFP is the most common cause of pain in primary, secondary and tertiary care level. The low back is the most common site of MFP.

Gauchat Marc-Henri – Switzerland – [marc-henri.gauchat@netplus.ch](mailto:marc-henri.gauchat@netplus.ch)

***Pitfalls in Manual Medicine – a Compilation of Case Reports.***

Three interesting cases from daily practice are presented with discussion of differential diagnosis: an unusual etiology for a crural weakness, an atypical acute cervical torticollis that is more complex than expected, and a case of chronic cervical pain with some surprises.

Gauchat Marc-Henri – Switzerland – [marc-henri.gauchat@netplus.ch](mailto:marc-henri.gauchat@netplus.ch)

***Radiological evaluation of the cervical spine in practice.***

In practice conventional radiology is still widely used. Consequences of minor trauma could be missed if the pictures are not systematically screened for indirect signs of fractures. Practical examples will be demonstrated.

von Heymann Wolfgang – Germany – [vonheyman@aerzteseminar-mwe.de](mailto:vonheyman@aerzteseminar-mwe.de)

***Headache – Recent results of basic research.***

**Part I:**

***Connections between extra- and intracranial tissues by trans-sutural nerves – a new model for understanding headache***

Nervous branches deriving from trigeminal, vagal and cervical fibers innervate all meningeal tissues. Recent research about the meningeal branch of the mandibular part of the trigeminal nerve revealed, that this n. spinosus in fact is innervating the dura of the lateral cranium, but that this nerve in addition has also fibers that leave the intracranial area by sutures around the temporal bone.

There is now proof that these fibers deriving from the intracranial spinosus nerve have afferents and efferents from and towards the extracranial periosteum as well as from and towards the temporal muscles, the temporal fascia included (deep somatic afferents).

Extracranial application of capsaicin induces intracranial release of substance P and CGRP, and extracranial application of local anesthetics could reverse this effect.

This neuro-anatomic correlation might be an explication for the eventual effect of cranial application of manual myofascial release techniques, i.e. to the temporal muscle and the myofascial structures of the cranium.

**Part II:**

***Pulsating headache and cranio-sacral rhythm – are there any connections?***

Concerning cranial rhythms, one may presume that the sensation of pulsating headache might be in connection with the pulse of the heart or another intrinsic rhythm of the CNS, as it is part of the hypothetical concept of the so-called primary respiratory rhythm used in the concept of osteopathy in the cranial field.

Recent studies and publications about the coincidence of the pulsating pain and the heartbeat found out that there is no correlation between these two rhythms. In addition, comparison with the so-called cranial rhythm of the osteopathic concept showed no correlation at all.

Investigation about the origin of the pulsation experienced in headache or tooth-ache indicate, that this perceived rhythm is produced by cranial neurons, being part of the alpha-power of the EEG, and similar to the neurons in the sinus knot of the heart. However, in adults these cranial neurons can act rhythmically only as an answer to a pathology.

Pulsating headache is an answer of cranial neurons to a structural or dysfunctional lesion and has nothing to do with the pulse of the heartbeat nor with the hypothetical cranial rhythm of the osteopathic concept.

Krasnoyarova Nadezhda A. – Kazakhstan – [krasnon555@rambler.ru](mailto:krasnon555@rambler.ru)

***Osteopathic and manual correction of biomechanical disorders as a rational method of elimination of pain syndromes.***

Functional biomechanical disorders in various systems of the human body form the generator of pathologically strengthened excitation and lead to the development of pathological pain systems. The generator of pathologically strengthened excitation results from structurally functional disorders of the physiology in the human body. From these pathophysiologic aspects, the therapy of pain syndromes consists of corrections of functional biomechanical disorders in the myofascial system and in the spinal system. Osteopathic and manual techniques tend to correct these disorders.

Our observation comprises the inspection of 3000 patients with various pain syndromes: 1250 patients with myofascial pain, 980 patients with neuropathic pain syndromes, and 770 patients with headaches. As all patients (100%) had biomechanical disorders in the myofascial system and in the system of the spine, we applied osteopathic and other techniques for their correction. Because of such treatment, we observed considerable re-course and reducing of the pain syndrome in 100 % of our patients.

Biomechanical disorders in the myofascial system and aial spine matter in pathogenesis of pain syndromes; therefore, osteopathic and manual correction of biomechanical disorders is a rational method of management of pain syndromes.

Kuchera Michael L., Barnes P. – USA – [mkuchera@marian.edu](mailto:mkuchera@marian.edu), Airaksinen – Finland – [Olavi.Airaksinen@kuh.fi](mailto:Olavi.Airaksinen@kuh.fi)

### **Research Perspectives: Cervical Palpatory Diagnosis & Treatment.**

A single, randomly-assigned intervention (selected from 5 different Manual Medicine [MM] corrective techniques) or a “touch sham” treatment was applied to “the most significant somatic dysfunction” in the cervical region of 240 subjects. Pre-MM and post-MM palpatory diagnosis and cervical hysteresis (tissue texture change) were examined independently by two osteopathic practitioners (MLK & PB). The palpating physician (MLK) wore pressure sensor monitors (IsoTOUCH®; Neuromuscular Engineering & Technologies, Nashville TN) and performed the randomized intervention. The 2nd researcher (PB) who was blinded to the site and type of intervention documented any quantifiable changes in four cervical hysteresis characteristics (fixation, motoricity, frequency and mobility) using a durometer (Ultralign SA201®; Sigma Instruments; Cranberry, PA).

A series of subset analyses was undertaken; two of which will be discussed in this short presentation.

- (1) 31 subjects had received high velocity low amplitude thrust MM to the occipitoatlantal joint
- (2) 34 subjects who had received mid-cervical post-isometric muscle energy or high velocity thrust technique returned 7-10 days later permitting a longitudinal analysis.

Interesting research results include consistencies in the diagnostic pressures used in diagnosis compared to pressures used to contact and remove the dysfunctional segmental barrier; variability in measurable changes depending on the type of MM used; and documentation of objective, measurable changes in tissue hysteresis that were still in effect 7-10 days following a single direct method MM intervention.

Subanalysis conclusions suggested by this data will be discussed in the context of the larger study and pragmatic clinical implications.

Rohrich Daphne C. – Netherlands – [d.rohrich@vumc.nl](mailto:d.rohrich@vumc.nl)

### **a. Physicians specialized in spinal manipulative treatment in The Netherlands: A description of their characteristics and their patients.**

There is little research done about physicians, who apply Spinal Manipulative Treatment (SMT) in daily practice. A distinct group of physicians in The Netherlands has specialized in musculoskeletal (MSK) medicine which includes also the use of SMT. The objective of our study was to describe the characteristics of these physicians and their patient population.

We used questionnaires and telephone interviews to collect data about physician characteristics. We extracted data about patient characteristics from our electronic register.

Most physicians specialized in MSK medicine after a career in other medical specialties. They used an array of SMT techniques and frequently referred their patients further for exercise treatment, physical therapy and postural treatment. They also used treatment options that, in The Netherlands, are only permissible for physicians, such as prescription of medication and application of injections. Comparison to data about chiropractors and manual therapists indicated that the patient population of MSK physicians presented with similar complaints as the population seen in The Netherlands by chiropractors and manual therapists. However, the patient population seen by MSK physicians and chiropractors had complaints of longer duration than the population seen by manual therapists. In addition, patients consulting MSK physicians had most frequently used other forms of SMT previously.

### **b. A large observational cohort study with an innovative web-based design.**

A web-based registry was established in June 2010 and has since then gradually been expanded. The first set-up consisted of a questionnaire, which was filled in by the physician at the first consultation of all new patients. In this questionnaire demographic information, the physician entered the type and duration of the main complaint and the type of concomitant complaints. In 2012, this registry was expanded with a web-based questionnaire distributed to the patients thus registered. In this set-up, all new patients were invited by email to fill in ques-

tionnaires at baseline and after various follow-up periods. This set-up was used until today in three different versions:

A first version was applied for three months in 2012. In this version, patients were asked at baseline about the average pain or average complaint in the week before the first treatment. After a follow-up period of three months, this question would be repeated together with questions about Global Perceived Effect (GPE) and patient satisfaction.

A second version was applied for four months in 2012 and the beginning of 2013. This version was supplemented at baseline and after a follow-up period of three months with several validated instruments to measure functional limitations, tailored to the patients' complaints.

The third version started in 2013, and this is still in use. This version comprises more generous baseline data and several follow-up measurements during a period of 12 months. Data from this study will be used to construct prediction models: can we predict from baseline data, which patient has the best chance to improve from the treatment, and which patient has more risk to develop side effects? We will also study whether these models are different for different SMT techniques.

Todorov Ilya – Bulgaria – [ilkotodorov@gmail.com](mailto:ilkotodorov@gmail.com)

### ***Sacroiliac joint dysfunction - clinical findings and manual therapeutic approach.***

In case of dysfunction, the sacroiliac joint is a major source of clinical findings and reflex changes. When examining patients, doctors quite often underestimate this. The joint participates in chain reactions with numerous distant anatomical structures, and sometimes it is difficult to reveal the primary pathology. The pain as a symptom usually is unclear, difficult to describe and not matching the usual diagnostic references. In Manual Medicine more often the pain is an expression of a functional limitation in the joint function. After a period of latency, the functional limitation starts to become a source of pain. The practice has shown at the same time that despite the lack of own muscles, the dysfunctions of the sacroiliac joint are mostly not isolated; so always another dysfunction should be considered.

The author provides a review on the characteristics and the differential diagnosis of the sacroiliac dysfunction. He will show preferred methods of examination, together with some manual techniques for joint mobilization, manipulation and post isometric relaxation.

*Key words:*

Sacroiliac dysfunction, chain reaction, mobilization, manipulation.

Vulfsons Simon – Israel – [S\\_vulfsons@rambam.health.gov.il](mailto:S_vulfsons@rambam.health.gov.il)

### ***CRPS and surprising reactivity to dry needling.***

Complex Regional Pain Syndrome (CRPS) is a severe chronic pain disorder that can develop spontaneously or after injury or surgery. Patients with CRPS display an exaggerated nervous system response to injury, usually in a distal limb area, resulting in pain and an autonomic nervous system response that is generally disproportionate in degree to the inciting trauma. CRPS is characterized primarily by pain manifested by allodynia, hyperesthesia, hyperalgesia and motor dysfunction. Swelling, trophic skin changes, sweating and abnormal blood flow commonly known as vasomotor instability are also part of the clinical picture.

Myofascial Pain Syndrome (MPS) is a very common musculoskeletal pain syndrome affecting up to 85% of the population in their lifetime. It is characterized by exquisitely tender trigger points located in a taut or tight band of muscle. Trigger points, the hallmark of myofascial pain syndrome, have been described in patient suffering from CRPS.

We describe five patients with CRPS treated by dry needling of trigger points in the proximal dystonic muscles. One patient had complete resolution of her CRPS syndrome, three had partial relief and one no relief at all. We postulate that their improvement stemmed from the improvement and resolution of their MPS and that in this small series of patients, MPS was the main generator of chronic limb immobilization, inflammation and vasomotor dysfunction leading to CRPS.

## B. Workshops

Vulfsons Simon, Finestone Aharon – Israel – [S\\_vulfsons@rambam.health.gov.il](mailto:S_vulfsons@rambam.health.gov.il) [asff@inter.net.il](mailto:asff@inter.net.il)

### **Workshop A:**

#### **Introduction to myofascial pain and dry needling. (4 hours)**

In our experience, myofascial pain syndrome (MPS) is the most common musculoskeletal complaint in the community. It is concomitant with almost all musculoskeletal conditions and its hallmark, the trigger point, is prevalent in both muscular and neurologically generated pain conditions. The pathophysiology of MPS is a topic under continuous research and proposed mechanisms included muscle energy imbalance, muscle super sensitivity due to radiculopathic changes and emotional issues. In all it appears that, the syndrome is a final common pathway resulting in a condition of pain, limitation of movement and reversible muscle weakness.

In this workshop, MPS will be introduced. We will include and discuss the following topics:

- The clinical presentation of MPS
- The pathophysiology of MPS
- The approach to diagnosis and recommendations for treatment

This workshop can be an important adjunct to the basic course in dry needling and manual medicine for MPS taking place in Varna on the 18-19<sup>th</sup> September 2016.

von Heymann Wolfgang – Germany – [vonheymann@aerzteseminar-mwe.de](mailto:vonheymann@aerzteseminar-mwe.de)  
Kuchera Michael L. – USA – [mkuchera@marian.edu](mailto:mkuchera@marian.edu)

### **Workshop B:**

#### **Part 1: Examination of cervical spine (2 hours)** (von Heymann Wolfgang)

Functional and palpatory examination of the cervical spine is the essential tool for manual diagnosis and a pre-condition for any decision for manual treatment. We will present this diagnostic approach of three steps: check for functional MOBILITY, palpate IRRITATION, and execute PAIN-PROVOCATION (M-I-P).

After an introduction into the anatomical and physiological situation of the cervical spine, we will follow the quite broadly used MIP diagnostic procedure to identify segmental dysfunction in this part of the spine. This will be done in a lab setting, including all participants.

#### **Part 2: Cervical manual treatment approaches (2 hours)** (Kuchera Michael L.)

Manual medicine (MM) approaches applied to the cervical spine follow logically from the discovery of somatic dysfunction in skeletal-arthrodial or myofascial structures. MM techniques can then be tailored to specifically modify biomechanical limitations and/or modulate key physiological processes.

This Part 2 hands-on treatment workshop will build upon the just completed “Part 1: Examination of the Cervical Spine” workshop. It will encourage participants to recognize patterns of objective findings related to sensitivity (tenderness/pain), asymmetry, restriction of mobility, and tissue texture change. Making a physiological assessment of underlying acute or chronic processes can provide pragmatic clinical insights into choosing an MM technique to optimally address that specific cervical dysfunction in that specific individual patient.

This hands-on laboratory will specifically address a few representative MM treatment techniques that are used to successfully treat regional pain and dysfunction. Modalities will include: (1) muscle energy activation using the oculocervicogyric reflex to target small suboccipital muscles; (2) suboccipital inhibition and decompression that has been shown to relax patients and enhance heart rate variability; (3) cervical counterstrain to enhance motion while decreasing inflammation; and (4) MM techniques that involve specific direct or indirect positioning of the cervical facet joints.

## C. Posters

Tae-Yong Park<sup>a</sup>, Jung-Han Lee<sup>b</sup>, Hoe-Cheon Yang<sup>c</sup>, Byung-Cheul Shin<sup>d</sup> – South Korea – [chungsul@msu.edu](mailto:chungsul@msu.edu)

### ***An introduction to Chuna manual medicine in Korea: History, insurance coverage, education, and clinical research in Korean literature***

<sup>a</sup> College of Medicine, Catholic Kwandong University, Incheon, Korea

<sup>b</sup> College of Oriental Medicine, Wonkwang University, Iksan, Korea

<sup>c</sup> Bareunmon Oriental Medicine Clinic, Seoul, Korea

<sup>d</sup> School of Korean Medicine, Pusan National University, Yangsan, Korea

The objectives of this study were to summarize the curriculum, history, and clinical researches of Chuna in Korea and to ultimately introduce Chuna to Western medicine. Information about the history and insurance coverage of Chuna was collected from Chuna-related institutions and papers. Data on Chuna education in all 12 Korean medicine (KM) colleges in Korea were reconstructed based on previously published papers. All available randomized controlled trials (RCTs) of Chuna in clinical research were searched using seven Korean databases and six KM journals. As a result, during the modern Chuna era, one of the three periods of Chuna, which also include the traditional Chuna era and the suppressed Chuna era, Chuna developed considerably because of a solid Korean academic system, partial insurance coverage, and the establishment of a Chuna association in Korea. All of the KM colleges offered courses on Chuna-related subjects (CRSs); however, the total number of hours dedicated to lectures on CRSs was insufficient to master Chuna completely. Overall, 17 RCTs were reviewed. Of the 14 RCTs of Chuna in musculoskeletal diseases, six reported Chuna was more effective than a control condition, and another six RCTs proposed Chuna had the same effect as a control condition. One of these 14 RCTs made the comparison impossible because of unreported statistical difference; the last RCT reported Chuna was less effective than a control condition. In addition, three RCTs of Chuna in neurological diseases reported Chuna was superior to a control condition. In conclusion, Chuna was not included in the regular curriculum in KM colleges until the modern Chuna era; Chuna became more popular as the result of it being covered by Korean insurance carriers and after the establishment of a Chuna association. Meanwhile, the currently available evidence is insufficient to characterize the effectiveness of Chuna in musculoskeletal and neurological diseases.

Şahabettinoğlu Ali – [info@maniplasyonmerkezi.com](mailto:info@maniplasyonmerkezi.com)

### ***Effectiveness of manual therapy in chronic low back pain: Retrospective study***

#### *Objective:*

The aim of this study is to reveal whether the patients with chronic low back pain benefits from manual therapy and their degree of satisfaction with retrospective analysis.

#### *Materials and Methods:*

The study was conducted on 168 outpatients that were aged over 18 and consulted physical therapy and rehabilitation center due to low back pain lasting more than 12 weeks. Inflammatory low back pain, thoracic pain, malignancy, steroid use, presence of infection and progressive severe neurological deficits were defined as exclusion criteria. Treatment sessions were carried out by a licensed physiatrist, twice a week. After the determination of pain intensity and degree of satisfaction by visual analog scale (VAS, 0-100 mm) patients were divided into three groups with the number of sessions required being <3, 3-6, and >6 in order to reduce the pain intensity below 40 mm.

#### *Results:*

There were 168 patients that possessed the inclusion and not the exclusion criteria. A significant recovery of pain was observed among all patients ( $p < 0.05$ ). Number of patients that required <3 sessions was recorded as 89 (%53.0), number of patients that required 3-6 sessions as 48 (%28.6) and the ones that went through >6 sessions as 31 (18.5). It was observed that there was no difference among the groups in terms of pain intensity during the comparison of the patients. When the degrees of satisfaction were evaluated, it was logically observed that the patients that went through more than 6 sessions had higher levels of satisfaction ( $p < 0.05$ ).

#### *Keywords:*

Chronic low back pain, spinal pain, manual therapy