2013

Principles of Manipulative Management of Essential Hypertension

Richard S. Koch

Follow this and additional works at: http://digitalcommons.pcom.edu/koch

Part of the Alternative and Complementary Medicine Commons, and the Osteopathic Medicine and Osteopathy Commons

Recommended Citation
Koch, Richard S., "Principles of Manipulative Management of Essential Hypertension" (Original Date Unknown, Online Publication Date 2013). http://digitalcommons.pcom.edu/koch/7

This Heart Disease, Research and Treatment is brought to you for free and open access by the Special Collections at DigitalCommons@PCOM. It has been accepted for inclusion in Koch Collection, Papers of Richard S Koch, DO by an authorized administrator of DigitalCommons@PCOM. For more information, please contact library@pcom.edu.
PRINCIPLES OF MANIPULATIVE MANAGEMENT
OF
ESSENTIAL HYPERTENSION

Richard S. Koch, D.C.
Olympia, Washington
PRINCIPLES OF MANIPULATIVE MANAGEMENT
OF
ESSENTIAL HYPERTENSION

My conviction, after 15 years in the general practice of osteopathic medicine, is that mechanico-physical factors are clinically the most frequently observed and most readily provable causes of chronic recurrent disturbed body function (both somatic and visceral). Being equally convinced that organic disease eventually follows if these factors persist unaltered, it would only seem consistent to desire to emphasize: that attention to these factors is paramount in the optimum management of essential hypertension.

For the most part in this discussion the mechanico-physical management will be the manipulative counterpart.

BASIS FOR BELIEF IN SPINAL CAUSATION:

Physiologists for years have many times over proven that, regardless of renal, hormonal, and other factors, the sympathetic and parasympathetic nervous systems mediate the most obvious control over the blood pressure changes in the body. Ordinary medical research has, perhaps with drug therapy or surgery in mind, demonstrated that interception of certain sympathetic vasoconstrictor impulses reduces hypertension. Osteopathic medical research however, indicates much more of significance to a hypertensive humanity. That is: that removal of certain mechanico-physical factors also can result in desirable reduction in blood pressure in patients with essential hypertension.

Ordinary medical research, despite present day alertness to obesity, heredity, "tension", et al., has found no consistent common denominator present in even the clinical observations of the majority of hypertensives. Osteopathic medical research however, indicates that the vast majority of hypertensives possess mechanico-physical somatic factors increasing sympathetic nervous system activity in the areas of the 3rd to 5th thoracic and
segments of the spine. These areas are manifestly palpable to the trained investigator, and subjectively to the aware patient. Furthermore, manipulative treatment to these areas can result in amelioration of the objective and subjective somatic manifestations but also in a reduction of blood pressure accompanied by a voluntary declaration of improved well being in the patient with essential hypertension.

It is the high incidence of clinical results in hypertensives treated by scientific corrective manipulation that would seem to attest to the presence of a mechanico-physical cause as being contributory in most cases of essential hypertension.

PURPOSE OF TREATMENT:

What are our immediate aims in treating essential hypertension? No one will contest that they should be, (1) pressure reduction, (2) relief of symptoms. In the majority of cases, scientifically considered manipulation can be expected to achieve both of these, though in varying degrees.

1. Pressure reduction: Precisely which degree of pressure reduction is desired in each case is debatable. Indeed, in many cases, the very advisability of attempting to bring about any lowering of the pressure is open to question. Furthermore, the degree of specific benefit such reduction may render each patient is, to date, likewise only in the realm of conjecture.

These points are to be recalled when manipulative attempts to lower hypertension may seem to be disappointing. If normalization of pressure to "160/90" is considered to be the lone goal in each case, then I am certain there are many of us who must frequently admit to failure. In my own experience I would have to state, that under such circumstances "curative" manipulation would be difficult of determination, difficult of proof, unreliable, inconsistent, and with unstable and but transient effects.
What then are we seeking? The utopia today would seem to be the lowest possible pressure compatible with optimum feelings of well being, safety, and efficient organ physiology. This varies of course, with each patient, and in my opinion is best left to the discretion to both the physician and the patient.

(2) Relief of symptoms: Regarding the relief of the patient's symptoms: here we can happily afford to be less arbitrary, more positive, and far more optimistic.

A proper application in patients with essential hypertension should almost certainly result in dramatic, moderately consistent, and sustained relief. Results can usually be expected to be reasonably assured to both patient and physician.

MANIPULATION AND OTHER MECHANICAL APPROACHES TO THERAPY:

How then shall we scientifically attack our problem? Certainly if our mechanico-physical factor, "the lesion", is a probable cause, it should be sought and removed wherever it may be. Speaking generally, the entire body economy must be considered by way of removing all soft tissue and articular lesions. All uncomfortable or annoying bodily ailments should be attended, insofar as these lower the threshold of the sensory system causing exaggerated response in any disease process.

"SPECIFIC" TREATMENT:

"Specificity" in manipulative treatment of essential hypertension can summarily be said to consist of correction and maintenance of the corrections of the 1st and 2nd cervical, the 3rd to 6th thoracic and 9th thoracic to 3rd lumbar segments. These areas are designated only because they are those which are most consistently involved.

In my own experience in a series of fifty patients with essential hypertension (by aid of standing "postural" radiographic studies) the thoracolumbar lesions were shown to be anatomically
parts of the apex of a spinal curve thus:

The upper thoracic lesions, either of a similar circumstance, thus: $\psi - 5 \, T$, or involved in a "strain" area at the base of a sharply angulated "list" of several vertebrae above, thus: $\psi - 5 \, T$

Significantly or not, in my own findings, most often these two patterns of spinal asymmetry occur together: thus:

As might be expected of course, a short lower extremity with sacral base tilt has likewise almost always been found to be present: $\alpha - 5 \, T$, $\phi - 12 \, T$. One might presume from L. R., both research evidence and theorizing, from knowledge of nervous physiology, that there likely occurs concurrent chronic disharmonious bombardment from these areas of somaticogenic sympathetic impulses to the higher vasomotor centers. Likewise similarly that one or both renal-adrenal centers are involved. Either or both of such happenings would seem to adequately satisfy the demands of scientific theory as to why a patient possessing such lesion patterns would seem more likely to develop hypertension. Moreover, the removal of these lesions should lower blood pressure in a hypertensive patient should seem acceptably explained in the light of the above.

**CORRECTION:**

Since it is only the principles of the manipulative management of essential and not the technique, hypertension with which we are now concerned, we shall merely emphasize that these lesions must be corrected. Correction must be by any or all necessary methods that can be assured of being corrective without superimposing injurious trauma.

Without postural x-ray studies of every case, it is difficult to understand how a manipulating osteopathic physician can serve his patient's best. Precise knowledge of the spinal
deformities, short legs, pelvic tilts, osseous anomalies, arthritic changes, etc., is most certain to be lacking without radiographs.

MAINTAINENCE OF CORRECTIONS:

This phase of manipulative therapy is most important in the treatment of any disease. Careless omissions in this matter, it is felt, are the largest, one factor in the failure to get desired and expected results with manipulation.

The methods of Martin Bielke, D.C., P.C., Wilde, D.C., et al., have in my hands proved most rewarding. They may be briefly summarized as being what I term a manner of attempt at some degree of "spinal reconstruction", both anatomically and physiologically. The purpose is to reduce spinal asymmetries as much as is practicable, and yet consistent with efficient and comfortable spinal physiology. After careful tissue evaluation (i.e., the degree of "give", elasticity, fibrosis, tenderness, etc.), the use of lift therapy is strongly considered and frequently used to "prop up" the un leveled base supporting a "slowly collapsing" spinal column. Our lesions are almost certain to recur more readily without such physiologic support. Of equal importance in the recurrence and maintaine ance of these lesions are the shortened muscles, ligaments and fascia on the concave side of the various segments participating in a curve or "list". These tissues act as does the bow string on a bow, preventing straightening or full "expected" physiologic motion of these segments.

In view of the presence of the inevitable, soft tissue fibrosis and contracture in such areas, gentle attempts at lengthening and stretching of these tissues are embarked upon daily by the patient at home. These are by prescribed specific stretching exercises, usually passive, creating no forceful activity on the part of the patient.

Example: Lying on one's side across a firmly rolled pillow, or similar device, on the floor serves to stretch and lengthen the involved tissues on the opposite side from
Lying on one's side up on one elbow with head in hand will stretch and lengthen the shortened upper thoracic and cervical tissues which may be maintaining the upper dorsal or cervical column in a condition of lateral list.

Lying on one's stomach while up on both elbows with chin in hands will lengthen shortened tissues in the area around upper thoracic lesions and asymmetries, as well as lengthen pathologically shortened anterior cervical tissues (fascial and muscular).

This latter condition usually accompanies upper thoracic spinal asymmetries with its frequent concomitant cardiovascular disorders. Various methods of localized traction also serve a similar purpose. When sitting for protracted periods patients can frequently benefit by placing a pad or book under the hip on the lumbar convexity.

One should guard against giving the patient the impression that he will have his spine "straightened." But far more often than not, both patient and doctor will be gratifyingly surprised by the degrees of "straightening" that actually do occur. Especially is this true in the lumbar area where motion is not restricted by rib "splinting." The patient should be made aware of good posture and breathing, it being far easier for him to stand and sit straighter than prior.

One must also warn the patient to expect new soreness, stiffness, or "l lameness" of varying degrees and duration if such home passive reconstruction treatment is prescribed. This is especially true in the elderly, inactive and malnourished and in damp or cold seasons. Small "doses" are meted out to comfortable tolerance. The older and less active the patient, the shorter and less vigorous should these home treatments be. Hot tub baths, heating pads, massage, and rubifacient ointments are prescribed at home for such discomforts as they may arise. It is strongly felt that so many of the "lame" reactions described from attempts at "pelvic balancing" and "spinal reconstruction" are in truth more due to undiscovered or untreated infections.
possibly conditions; and also due to dietary or postural insults. With this in mind, and from my own experience, I have not in the least been deterred from continuing such a program in practically any hypertensive. When followed persistently, the rewards have been too gratifying to consider its proscription.

Periodic corrective manipulation is administered; and the home treatment by the patient will prove a real advantage in both correcting and maintaining corrections.

The patient is re-xrayed at 3 to 6 month intervals (with lift under short side) until as much change toward spinal symmetry is achieved as would seem possible. This would mean, when serial x-ray studies reveal a level sacral base and/or when the spine no longer reveals evidence of "continued improvement" toward a balanced pelvis and symmetrical spine. Manipulative correction should be administered periodically when needed. Subjective distress of a somatic or hypertensive nature are the deciding criteria. It is recommended that the physician familiarize himself with the general principles involved in treating "curves", "lists", and scolioses; as these are the basis of treatment in the above described conditions.

Other general manipulative measures indicated in the treatment of essential hypertension are briefly cited herein. (They are general contributions only; the burden of proof lying more heavily upon them were they to be considered "specific")

Transient soft tissue manipulation may be administered by slow, deep, comfortably pleasant pressure throughout the paravertebral musculature. Neuro sedation is experienced subjectively. Traditionally it is considered preferred to treat and the benefit of a tonic effect.

Muscles and ligaments of the extremities, when gently stretched, seem to increase the feeling of generalized pleasant relaxation; apparently by way of a harmless dissolution of tension producing sympathetic impulses.
Direct manipulative approach to the cranium and viscera has been used with claims of benefit.

Abdominal semi-elastic supporting belts are known to improve general bodily functions related to the commonly "sagging" abdomen. These should be prescribed whenever it is suspected that cardiac, respiratory, or other visceral or spinal physiology might be benefited.

UROLOGICAL OBSTRUCTIONS:

It has been observed, not a few patients with essential hypertension, experience a persistent reduction of blood pressure to "normal" via serial sounding of strictured urethrae and ureters related to prostatism, and cicatrix. This may seem "stretching a point" to include such observations among manipulative measures, however, it nevertheless illustrates the influence of various mechanical impediments on remote body functions.
We are all only too much aware of the fact that the last word in research in osteopathic medicine is far from present day comprehension. And it is likely true that many of tomorrow's valuable, proven, scientific revelations are, today, unfortunately but the convictions of an isolated individual or small minority group, each intent upon investigating and teaching "a new truth". With this in mind, it is herein noted that a summary of any therapy must of necessity omit many valuable points of information, technique, and procedure. The presentation of each of us, furthermore, is regretably limited by his own experiences.

**SUMMARY AND CONCLUSION**

1. Ordinary medical research has demonstrated that the most obvious control of blood pressure changes in the human body are via the autonomic nervous system.

2. Osteopathic medical research has implicated commonly occurring mechanico-physical spinal circumstances ("lesions") as being productive of elevation of blood pressure in the human.

3. Clinical observations have noted an impressively high concomitance of these factors occurring with essential hypertension in studied patients in the areas of cervical segments 1 and 2, and thoracic segments 3 to 6, and 9 to 3rd lumbar.

4. In a series of fifty cases of essential hypertension, manipulative treatment directed toward correcting (and maintaining correction of) these lesions has resulted in the most effective manipulative management.

###

**REFERENCES**


###