

SPINE THERAPY IN CERVICAL AREA – LIMITS AND EFFICIENCY

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Abstract: *Pain on the cranial extremity and superior limb's level is dominant symptom of the vertebral static disorders in cervical area. The diversity in determinants and favorable facts will create a multiple symptoms, as intensity and localization. The vertebral therapy that will be applied in the organized way, individual or in long terms recovery program, sustained a favorable evolution for main symptoms, to remission or to new forms.*

Key words: *cervical spine, vertebral therapy, pain*

1. INTRODUCTION

The present research was conducted during September 2014 – March 2015, at the Day care Centre for Elder Persons „Hope”, which is subordinated to The Foundation for Community Services, Bacau.

The aim of this study is to underline the limits of spine therapy, applied to the spinal column, in two kinds of affections (cervical spondylitis and cervical brachialgia).

2. CASE STUDY

The symptomatology that goes along with the vertebral static dysfunctions of various etiology, (inflammatory processes, degenerative processes, inflammations, unhealthy positions, climacteric period, etc.), is very complex. Starting with the specific manifestations of cerebral ischemia (pain, vertigo, fatigue, lack of concentration, limitation of the physical effort and walking) and continuing with the pathology of the cervical column (localized pain or irradiating ache in the thoracic member, functional impotence, joint blockage and muscular rigidity) we can describe a very vast clinical area, that provoke the complementary disciplines, each with it's specific therapeutic action (medicine, pharmacology, psychology, psychiatry, physical therapy, reflex therapy, bio energy therapy, etc).

The pain experienced at the cephalic extremity and of the superior limbs, is by far the dominant symptom of vertebral static in the cervical zone. The diversity of the etiological and stimulating factors creates a diverse variety, regarding the intensity and the localization.

This study focused on two cases.

First case: patient I.M., age 52, retired (worker at industrial factory), presented a multiple diagnosis (peripheral vertebral arthrosis; cervical spondylitis post-climacterium; essential artery hypertension, second degree; chronically painful cardiopathy ischemia; second-degree obesity). The functional examination revealed: limitation of the

movements and cracks during the mobilization of the coxo-femoral joint and the bilateral knee; thigh paresthesia; limitation of the movements at the cervical spine level; equilibrium loss when sudden movements occur and in the morning when the patient rises from the bed; pain at the cephalic extremities level (cephalalgia, spots at the sinuses and occipital level) and sore neck; psychical discomfort and sleep deterioration.

The recuperation treatment (two sessions a week) was directed towards the following objectives: mobility increment at the vertebral column level; decrease of cephalic pain at the neck level; increasing the psychical comfort; reflex therapy after the normalization of artery tension.

Second case: patient C.M., age 51, retired (driver), had a multiple diagnosis (bilateral cervical-brahialgic syndrome; lumbar discopathy; type two diabetes; essential Artery hypertension, stage II; transitory ischemia accident; hypercholesterolemia; obesity, second degree. The functional examination revealed: mobility limitation of the scapula-humeral bilateral joint, mainly the left one; lumbar soreness along with reduced area mobility; mobility limitation at the cervical spine column level; neck ache and soreness when scapula-humeral joint is mobilized.

The recuperation treatment (three sessions a week) was directed towards the following objectives: mobility increment at the cervical and lumbar vertebral column level; pain decrement at the neck and bilateral scapula-humeral joint level; mobility augmentation at the bilateral scapula-humeral joint level; reflex therapy for the scapular belt and lumbar vertebral column.

3. METHODOLOGY

Spine therapy (or vertebral manipulations) suggests a well-structured, complex method, directed towards the soft elements near the joint and the vertebrae. Its applicability is more efficient for the two mobile segments of the spine (cervical and lumbar) compared to the other two less mobile segments (thoracic and sacral).

In my study we have applied vertebral therapy, at the individual level and also included in a long period recuperation program (6 months). Our main objective was the cervical spine and the scapula-humeral joints.

The application technique was structured into a maneuver circuit (the patient is sitting on a chair only he is sitting with his face at the chair hold, he is standing very still, and keeping this position all the time he is going through the procedures):

- Head and neck flexion. The therapist puts his hands on the posterior parietal area and his elbows are on the patient's shoulders;

- Head and neck extension. The therapist sits on the side with his hands on the chin and at the C7 level;

- Lateral inclination of the head. The therapist's hands are on the lateral cervical spine and on the collateral parietal area;

- Twisting of the head. The therapist has his hands on the chin and on the shoulder that is in opposition with the movement;

- Flexion of the head and neck. With his hands on the back head, the therapist inserts his hands from front to back, through the space that is created between the patient's arms and head, over his arms or under them (the key "double Nelson", from free fighting or Greece and Roman fights);

- Traction of the head and neck along an upper axis. The therapist puts his index finger beneath the cheek or on the temples, with his pollex at the occipital level, the area between the two fingers being intimately attached to the patient's skin;

- Extension and crossing the superior members. The therapist holds the patient's fists joints;
- Extension and abduction of a superior member. The therapist holds the fist joint and the counter lateral shoulder;
- Horizontal adduction and crossing of the superior members. The therapist holds the fist joints.
- Horizontal adduction of the superior member. The therapist holds the fist joint and the counter lateral shoulder;
- Abduction and flexion of the superior member from the shoulder. Flexing the elbow and keeping his hand on the patient's back head, the therapist proceeds at the elbow level and the opposite shoulder.

4. RESULTS

For cervical spondylitis the results are good (that are obvious when we look at the mobility of the cervical spine), while they are very good for cervical-brahialgia (especially at the scapula-humeral joint level, but for the cervical mobility as well).

The pain, that represents the main cause for witch patient's resort to rehabilitation, had a favorable evolution.

In the case of M. I., the cephalic extremity pain has diminished. After a week the patient still presents a mild soreness, and the aching areas around sinuses and the occipital appear only in the morning; at the cervical spine column level, the pain occurs when there are sudden temperature alterations and pressure modifications, rarely when unhealthy positions happen.

For patient C. M., the pain has completely disappeared and at the scapula-humeral left joint, occurs when stretching and forced movements happen.

5. CONCLUSIONS

Applying the vertebral therapy for these two cases, we were able to observe a favorable evolution of the main symptoms. Some of these symptoms have been remitted, while others presented special appearances.

Spine therapy is a method that encompasses demonstrated therapeutic valences. The patient's individual features and the characteristics of every therapist's technique account for the differences that have been noted, not only through this study, regarding its limitations and its efficiency.

REFERENCES

1. Baci, C., *Functional Anatomy and Biomechanics of Locomotors Apparatus*, București: Sport-Turism (1997).
2. Epuran, M., *Research Methodology of the Bodily Activities*, București: ANEFS (1996).
3. Harry, St., *Artroza*, București: Corint (2003).
4. Marcu, V., Copil, C., *Massage and Complementary Techniques*, Oradea: Universitatea (1997).
5. Mârza, D., *Ameliorarea actului recuperator kinetoterapeutic prin implicarea factorilor de personalitate și aplicarea legităților psihologice ale relațiilor terapeut-pacient*, Iași: Tehnopress (2005).
6. Mârza, D., *Special Massage Techniques*, Bacău: Plumb (1998).
7. Moțet, D., *Sfaturi pentru o viață activă prin kinetoterapie*, București: Semne (2013).

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