Dynamic Chiropractic

SOFT TISSUE / TRIGGER POINTS

Integrative Fascial Release (IFR)

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IFR is a fascial release system which combines a variety of present-day soft-tissue concepts into a new paradigm. A discussion of IFR first appeared in the November 1998 issue of *Chiropractic Technique* as "Genitofemoral Entrapment Using Integrative Fascial Release."[1] IFR in this paper included pertinent elements from methods developed by Lewit,[2] Barnes[3] and Leahy.[4] Most recently, additional elements to IFR have been included from Roth,[5] Greenman[6] and Weiselfish-Giammatteo.[7]

The paper in *Chiropractic Technique* was a case study of a 32-year-old female with a complaint of groin pain over a period of three and a half years. One of her treatments included a surgical section of her ilioinguinal and iliohypogastric nerves at the pelvic brim, permitting the nerves to fall into the pelvis. Unfortunately, her pain persisted. Definitive findings in her case included groin pain on lumbar extension, a shortened iliopsoas on the side of involvement and reduplication of pain upon pressure over the involved psoas major.

The pain was due to entrapment of the genitofemoral nerve as it passed through the psoas muscle into the psoas fascia, which makes up part of the anterior layer of the thoracolumbar fascia. Sammarco and Stephens[8] mention how psoas muscle hypertrophy within its fascial compartment may further add extrinsic pressure to the nerve.

IFR assumes that one of the most frequent sites of soft tissue involvement relates to the three dimensional fascia, which surrounds, supports and penetrates most of our body. This statement does not presume that it is the only soft tissue that must be treated, but that fascia is extremely important and related to many soft tissue problems not previously realized (see "The Fascial Connection," *DC,* December 14, 1998 and "Book Report on Fascia", *DC,* January 12, 1999).

Using the concepts of Barnes, Lewit and Leahy, the whole body must be observed from a fascial point of view including postural faults and torsioned pelvis. Both the superficial and deep fascia on the whole body must be palpated for solidified abnormal tension. Muscles (fascia) are also tested for chronic shortening. Areas chosen to treat must first be palpated for the direction of the barrier upon which a contact is made. The barrier is held usually from 10 seconds to one and a half minutes until a release is felt which is then followed. During the following of the fascia, a local extremity can be actively stretched or moved by the patient in the direction of the fascial restriction.

Most recently, I have been using a "tensegrity therapy" method developed by Roth[5] which determines a possible primary source of the fascial restriction, which may be distant from the source of the pain. Another technique that fits extremely well into fascial release is a "3-planar fulcrum myofascial release" technique developed by Weiselfish-Giammatteo[7] which treats the fascia in three planes simultaneously. Finally, there is Greenman's[6] helpful method of adding the breathing factor which "enhances" the movement of restricted fascia.

Just as all of the above contributors have derived information from previous authors to develop

their methods, so have I in developing IFR. As my friend Dr. George Goodheart always says, it is just adding more pieces to the puzzle.

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