

Soft Tissue Serendipity

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While flying into Minnesota last month a lady sitting next to me asked me what I was going to do in Minneapolis. "I'm lecturing on soft tissue," I replied.

"Soft tissue, how interesting," she commented. "How long is your lecture?"

"Twelve hours."

She shook her head. "That's amazing."

"Why is that amazing?"

"I can't believe that anyone could talk for 12 hours on toilet tissue," she marveled.

She's given me a fabulous opening line for future lectures.

Practitioners such as John T. Barnes and others have been evaluating and treating the bodily fascia for years. They have reported outstanding results in many chronic conditions that have failed to respond to most other types of treatment.^{1,2} Like many other methods of treatment and evaluation, often the clinical results are demonstrated well before the scientific basis is explained.

In a recent article in *Spine*³ on the pathomorphology of thoracolumbar fascia in chronic mechanical back pain, the authors found "serendipitously, microscopic changes suggestive of ischemia or inflammation" in the thoracolumbar fascia. They examined for the first time the fascia in patients with mechanical or arthropathic (pain from articular disease, not radiculitis) back pain patients. Their own literature review on fascia revealed that all previous investigations of the ultrastructure of fascia by light and electron microscopy was only done on normal patients. In these previous control (no back pain) tissue specimens the presence of nerve innervation was found.⁴ In the fascia of the low back patients they found no neural end-organs in any of the specimens. The authors stated, "The thoracolumbar fascia may be deficiently innervated in problem back patients." They did find small peripheral nerve endings associated with foci of degenerative change within the fascia. They also found submicroscopic foci of calcification and precalcification often seen in ischemic or inflammatory conditions. They concluded that "these serendipitous observations are suggestive of a primary ischemic patho-anatomy in the fascia that may be of relevance to back pain syndromes."

In 1987 Barnes⁵ wrote that the release of fascial restrictions "will elicit a vasomotor response, increasing blood flow to the affected area, enhance lymphatic drainage of toxic metabolic wastes, realign fascial planes, and most importantly reset the soft tissue proprioceptive sensory mechanisms."

Abnormal fascia can be detected by lightly pushing the skin in different directions and noticing the barrier that does not allow normal skin movement. Usually a deeper rolling pressure into the tissue

below the abnormal skin movement will reveal a "piano string," or wiry or leather-like tissue. This represents solidified fascial restrictions. This type of tissue is often revealed in the paralumbar area at the T11 to L2 level which may be a compensatory area of fixation for hypermobile L4, L5 spinal segments.

Release of these areas and the restoration of pelvic torsions by myofascial treatment often relieves the chronic pain at these levels and allows the adjustment of these areas to "hold." It's a far cry from "toilet tissue."

References

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