

Effect of craniosacral therapy as a treatment of chronic tension type cephalgia: A case study

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Abstract

Chronic Tension-type headache (CTTH) is a highly prevalent condition experienced annually by 30-70% of the population. As a chief complaint, it occupies 5-8% of physiotherapist caseloads, but is probably more prevalent in multiple complaint cases and is a difficult topic to address. It is difficult for the patient because there is no truly effective medical treatment. The role of non-pharmacological therapies in the preventive treatment of tension-type headache (TTH) is still an object of debate. The primary aim of this case study was therefore to investigate the therapeutic effect of craniosacral therapy in CTTH.

Introduction

Cephalalgia is the term used to designate all sorts of pains located on the head. It is one of the most common causes of pain on adults and one of the most disabling ones. The cephalalgias may be primaries or secondaries, according to the aetiology. The tension-type one, which is a primary kind is the most common variant of all kinds of cephalalgia, affecting a substantial part of the general population. This kind of cephalalgia is known as tension, due to the muscular contraction. It is classically featured as pain on constrictive character, usually bilateral, with mild to moderate, not aggravated by daily routine physical activities and during between thirty minutes and seven days. It may be ranked in episodic, when occurring on less than 180 days per year and 15 days per month. Alternatively, it also may be chronic, when its frequency equals or overcomes these rates (15 days a month), for at least three months. The unenviable accumulation of certain metabolites concomitant with one's life style and emotional state of mind brings on symptoms resulting to tension-type cephalalgias. Therefore, the praxis of manual therapy due to its effects on one's structure also supports on the cephalalgia's alleviation, diminishing such symptomatology.⁽¹⁾

Patient's Information

The patient examined was a 44-year-old male with neck pain and a pressing headache, which continued for 5 days a week with moderate intensity for the last year. He had been treated by a neurologist some years ago with non-steroidal anti-inflammatory drugs (NSAID) with no improvement. The first-day interview and clinical exploration showed bilateral location, pressing, deep burning sensation and more than fifteen days of headaches a month for the last 12 months. Symptoms were not aggravated by physical activity and accompanied by photophobia. The patient was known to have CTTH by a neurologist according to the international classification of headache disorders.⁽²⁾

Clinical Finding

The subjective examination showed that the patient had a forward head posture. The ranges of cervical motion were measured with the cervical range of movement device (CROM) and pain during cervical extension and lateral bending; however, were within normal values. In a manual physical examination, stiffness and limited cervical accessory mobility were observed at the atlanto-occipital (AO), C1-2, and C2-3 segment and manual palpation revealed presence of myofascial trigger points in the neck muscles (sternocleidomastoid, upper fibers of the trapezius, sub-occipital muscles and spinal muscles). Cranial Mobility was found to be decreased with Right rotational fault.⁽³⁾

Treatment

After taking signed consent from the patient, manual therapy of sub-occipital soft tissue inhibition is performed with patient in supine position. The patient's head leans against the physiotherapist's hands, which palpate sub-occipital muscles by sliding fingertips until contacting posterior arch of atlas. At this point, a deep and progressive gliding pressure is applied. The purpose of this technique is to release sub-occipital muscle spasm, which can be responsible for the mobility dysfunction of the occiput-atlas-axis joint. Craniosacral therapy was given as follows: Sacral release, Pelvic Diaphragm release, Abdominal Diaphragm release, Thoracic Outlet release, Hyoid release, Occipital-Atlantal junction release, Frontal lift release, Parietal compression, Parietal lift, Sphenoidal compression, Sphenoidal decompression, Temporal release, Mastoid wobble, Still point release, TMJ compression, TMJ decompression.^(4,5) Treatment was given on alternate days. After first sitting the symptoms were reduced by 60%. After second session the symptoms were reduced by 80%. After third session, the symptoms were reduced by 90% and at the end of the fourth session the patient was symptom free. The patient was called after every 15 days for his follow up visit. At third follow up visit the patients symptoms were reproduced by 20%.

The patient was again given treatment and after the treatment session he was completely symptom free. The patient has not complained of any symptoms since then.

Discussion

Magoun quotes Pritchard, Scott, and Girgis, who showed "that minimal motion does exist between the bones of the skull." This literature is consistent with the cases being treated here. In the cases of chronic tension type cephalgia reported in this case, there is decrease in cranial mobility with right rotational fault. Applications of osteopathic techniques increase the mobility of the cranial bones and correct the existing rotational fault.^(6,7) This possibility needs much greater research and large-scale case-control studies.

References

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