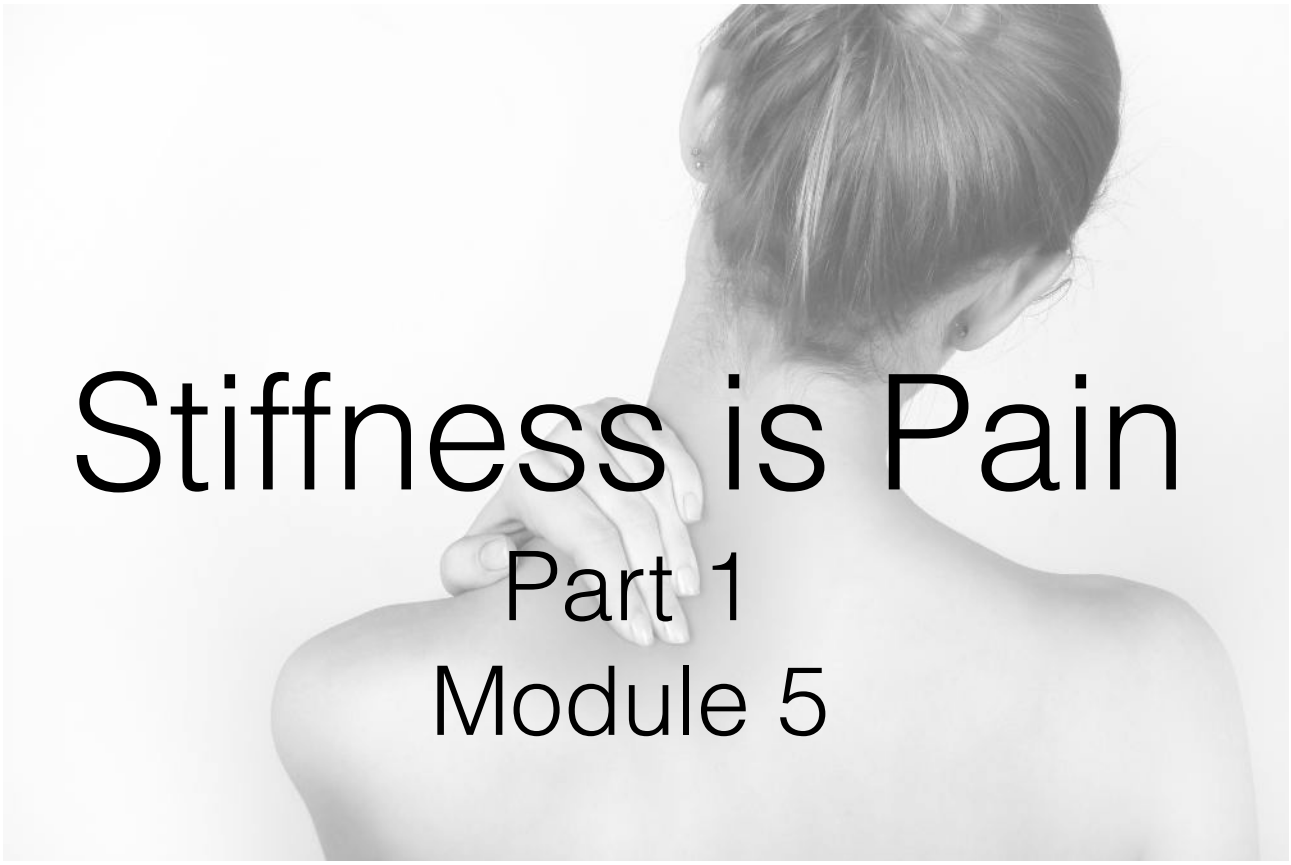

Stiffness is Pain

Part 1

Module 5

Kingmyopro

Stiffness is Pain Part 1

King Myo Pro Module 5

Stiffness IS pain – What am I talking about?

Add your notes here

I stumbled across this observation whilst assessing range of movement in a patient's neck many years ago. For no apparent reason I decided to interpret the location where the patient was describing stiffness as a myofascial pain pattern. In other words when the patient described 'stiffness' in the right upper neck as they rotated to the right, rather than treating the upper neck I decided to treat the muscle that I knew could refer PAIN to that location. Instead of interpreting the patient's upper neck symptom as a 'stiff' muscle local to the upper neck, I decided to interpret the patient's sensation of stiffness as a very low-grade 'myofascial pain' sensation.

In this particular patient's case, the pain pattern was that of upper trapezius. The pattern was not complete, ending at the mastoid process behind the ear, not extending to the temple, and the sensation only occurred upon rotation to the ipsilateral side at the end of the range of movement.

So … I did not touch the upper neck where the 'perceived' stiffness was, but treated Travell and Simons' trigger point one location immediately superior to the clavicle on the border of the upper trapezius. Voilà! Full range of movement and 'stiffness' in the upper neck gone!

Ever since that day, whenever I assess range of movement in the process of consultation, I consider the possibility that where the patient is describing 'stiffness' – that the location of that stiffness is quite possibly a myofascial referred sensation rather than a restriction at the site of the stiffness.

This single concept has revolutionised my approach to assessment and treatment.

Now, whenever I treat and assess range of movement, I pay attention to the exact location of the patient's stiffness and my first palpatory assessment is just about always searching trigger point locations that can refer 'pain' to the vicinity that the patient is describing as the source

of their stiffness, rather than palpating the muscles in the vicinity of the stiffness itself.
I will then assess by palpation the trigger point location(s) and more often than not identify a trigger point/fascial restriction. After a brief cross-fibre form of manipulation I retest the range of movement. Continuing to manipulate and assess until the range of movement is full and stiffness free. In most cases I have not touched the location of the perceived stiffness. Whether it's a groin restriction caused by adductors, a hip pattern caused by gluteals, a knee pattern caused by vastii or a neck pattern as mentioned above, this concept has proven to be one of the most critical concepts to the effectiveness of my treatment for the last decade.

A caveat about Travell and Simons' myofascial pain patterns . . .

Of course the starting point for this whole discovery is dependent on my (and your) knowledge of Travell and Simons' charted myofascial referred pain patterns. Travell and Simons' have attributed their referred pain patterns to myofascial trigger points and they have theory that describes the physiology of trigger points.
Recent study has thrown the trigger point theory and even the existence of the trigger point into some doubt, according to some researchers. The purpose of this article is not to try to validate the physiology of trigger points, that is a whole other discussion.
What, in my opinion, is irrefutable is the existence of myofascial pain patterns. Whether Travell and Simons' trigger point description/definition is perfect matters not. Whether myofascial pain is described more accurately as arising through the fascial web rather than from 'taut bands' matters little. The fact of the matter is that myofascial pain is consistently clinically observable and reproducible – and brilliantly charted as a result of the 50 or more years of observations compiled by Janet Travell and David Simons in their seminal Myofascial Pain and Dysfunction – Trigger Point Manuals.

An example: adductor magnus.

I will always assess restriction in the adductor groups when treating a patient with chronic or reoccurring lower back pain.

Why?

Because restriction in the adductors has a profound effect on lower back stability. Especially asymmetrical restriction. And most lower back pain sufferers are completely unaware of any restriction in their adductors – but that's for another article.
I have selected adductor magnus because this restriction is common and a very good example of the concept I am describing.
Range of movement in the adductor group is easily assessed with the patient lying supine and the hip and knee flexed as the knee is dropped out to the side abducting the thigh.
As the limb moves towards the end of its range of movement the patient will either describe a 'painless' or 'stiffness free' stop, even when I put some downward pressure on the knee. Alternatively they will describe 'stiffness in the groin', pointing to a diagonal line of stiffness inferior to the inguinal line and perhaps 'pulling' distally somewhat. Now bear in mind that the patient may never have experienced 'pain' in this vicinity and in many cases had not even noticed that one groin is 'stiff' compared to the other until you pointed it out.
Sometimes the stiffness is so subtle that it is not even perceived until one thigh is compared to the other and I ask 'Is one easier than the other?'
Although patients' actual range may vary, as long as there is a painless, stiffness free 'stop' at the end of the range then the adductor group is healthy. Even when, under full ROM a patient says 'It feels fine' I go out of my way to ask:
'Is there any pain there?'
'No.'
'Is there any stiffness at all or does it just stop?'
'No. It just stops.'
This answer and this answer alone is satisfactory in seeking to address and resolve myofascial restrictions properly.

Adductor magnus treatment . . .

Now, if you read Travell and Simons' observations regarding this pain pattern you will know that although the trigger point is mid-thigh the pain pattern itself commences at its proximal end – in the groin. It is only when the pain intensifies that it is felt radiating toward the knee (see TrP manual Vol 2, Fig. 15.2 Adductor Magnus TrP1). So … I am not expecting to see the whole pattern, if the pain is subtle I will only see the proximal groin component of the pattern.
The reason I said this was a good example is because, assuming trigger point one is the cause of the stiffness, then manipulation to resolve this stiffness is far from the stiffness symptom. Nonetheless, I have observed this on many occasions. Successful release of trigger point one may

require several repetitions of manipulation and range assessment until the stiffness in the groin is eliminated completely and the range of movement, now increased, simply feels like a pain free, stiffness free stop.

Adductor magnus differential assessment . . .

Now I have seen several cases where the groin stiffness was caused exclusively by trigger point one in adductor magnus and the process of resolution was as simple as I just described: One pattern > one trigger point > dramatic improvement in range of movement and no stiffness. But … we all know that life is rarely so neat.

Often after resolving 'trigger point one', the pattern associated with it will resolve but on reassessing movement another pattern will appear. This will seem like the pattern has 'moved'. It has not moved. The pattern you were treating has resolved and now the patient is feeling a pattern from a different trigger point. Often at this point the patient will state that the stiffness is still there. Be sure to ask again 'Exactly where is the stiffness?' because it may be 'still there' but a slightly different location. It may be a pattern from one of the other trigger point locations in adductor magnus or it may be from a different muscle altogether.

When this is the case, repeat the process. Determine exactly where the stiffness is, determine which trigger points can refer to that location and start searching for trigger points associated. This is then worked through as a process of elimination until all muscles that contribute to that range of movement are trigger point free and the patient experiences a pain free, stiffness free stop.

Start thinking this way and your effectiveness as a therapist will increase . . .

When you begin to consider stiffness AS pain and combine this knowledge with a form of trigger point manipulation that is effective and quick, then you will begin to be able to address the subtle biomechanical compensations that are present underneath all chronic musculoskeletal pain complaints. The secret in solving the chronic pain lies in restoring functional 'stiffness free' movement in the secondary and tertiary areas associated with the dysfunction.