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The Complex Shoulder Trigger Point Therapy Course

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NAT Pro Series:

Treating the Complex Shoulder

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Welcome

Welcome to our advanced NAT Master's course. This course is best taken after you have completed our five-hour NAT Access course. We would also recommend you take the case history and differential diagnosis courses.

The Master's course covers the full spectrum of the NAT for the more stubborn cases and adds modifications for a range of complex shoulder complaints.

Once you have completed this NAT Master's course, you should take the reflective learning exam in order to receive your Master's certificate.

NB: Videos will open in a new browser window.

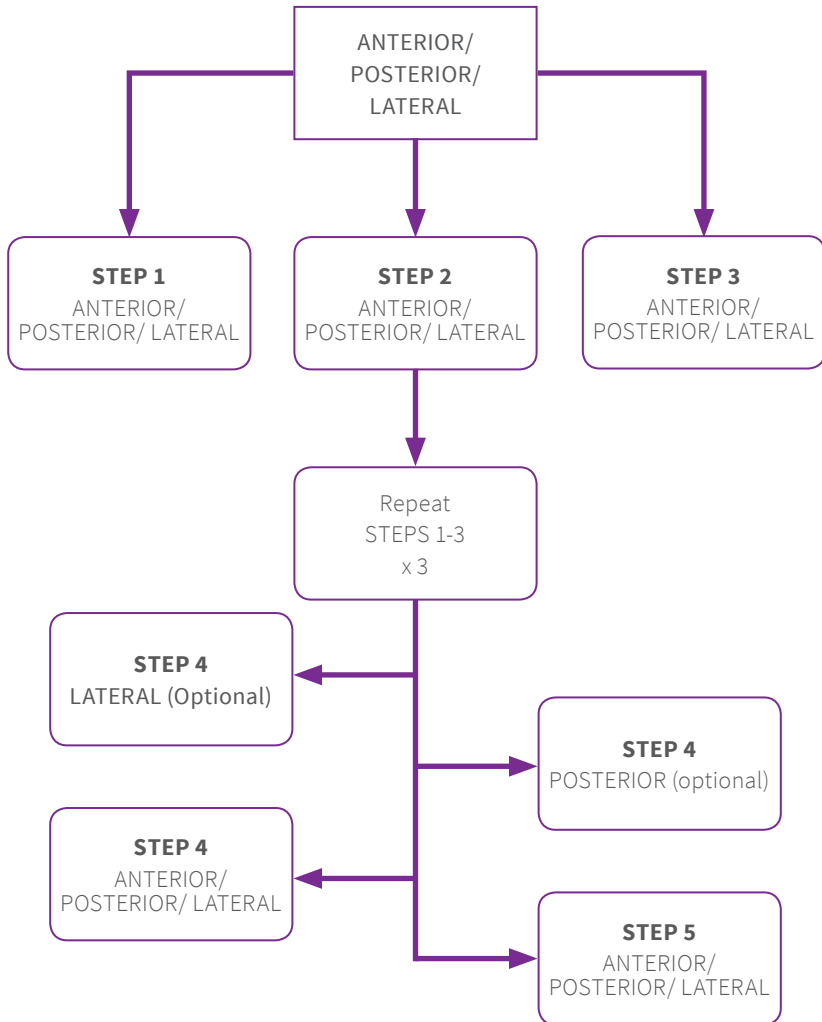
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Part I

In the Access Course we covered the basic **STEPS** of the technique. Now we are going to “flesh out” the nuances of the Niel-Asher Technique™ - designed to help you develop your management strategies for all cases. **Please read and then watch the videos as directed.**

Overview (ROLL OVER TEXT AND CLICK TO WATCH VIDEOS):



Typical Combined Presentation

STEP 1 - ANTERIOR/POSTERIOR/LATERAL

Talk the patient through the maneuvers where possible. The emphasis is for the patient to relax into your pressure. This step is aimed towards the fascial tissues in the midline of the lateral upper extremity.

Perform several deep, slow strokes in one direction only from the elbow towards the head. You should feel a long, tight band up the arm with nodules embedded in it.

You can achieve different results by varying the force and velocity.

Increasing the speed of the stroke causes an isometric contraction of the deltoid muscle. This has the effect of rapidly increasing abduction. Increasing the force (remember, more force, less speed) will also cause isometric contraction of the deltoid, but the results are not as rapid. You would use this if the patient is:

- Very “stuck” or “rigid”
- Diabetic
- Large muscular male/female
- A complex or “difficult” case

Occasionally the tight band is POSTERIOR to the midline.

Moving upwards through the band, apply slow and steady pressure on these nodules. The nodules vary in size from a pea to a large coin. They tend to accumulate:

- Near the elbow
- At the insertion of the deltoid
- Under the acromial arch (see STEP 4 LATERAL)

This is a fascial condensation – probably generated by the strong pull of the hypertonic deltoid and its fascia. Follow this with a gentler effleurage massage to the whole arm (upwards only). This should be a light stroking, more general and thus a little faster in tempo.

PATIENT LYING ON THE GOOD SIDE (or better side if bilateral)



[Click here to play video \(video will open in new browser window\)](#)

Variations for STEP 1 - Complex Anterior Shoulder

Try using your elbow!!!

After some practice, the elbows are the perfect applicator for this technique. You can be sensitive, but can also generate more force when needed. Remember, practice makes perfect.

Be careful not to go too fast as this can bruise the patient. Do not use force - until you are extremely competent, simply “lean” your body weight.

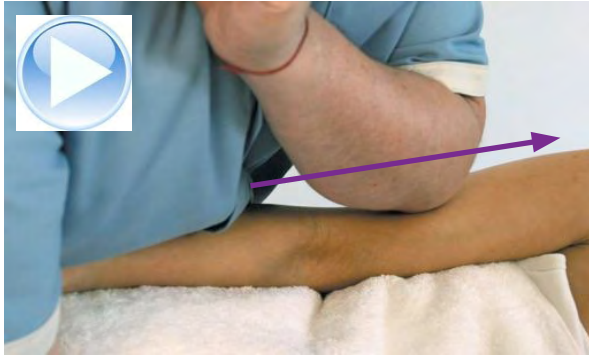


[Click here to play video \(video will open in new browser window\)](#)

POSTERIOR aspect of upper extremity

This is more appropriate for a posterior of lateral presentation. Here, you might find a tight band towards the back of the outside of the arm.

Trace this band back to its origin; this is usually an exquisitely tender spot near the back of the glenohumeral joint. Rest on this spot.



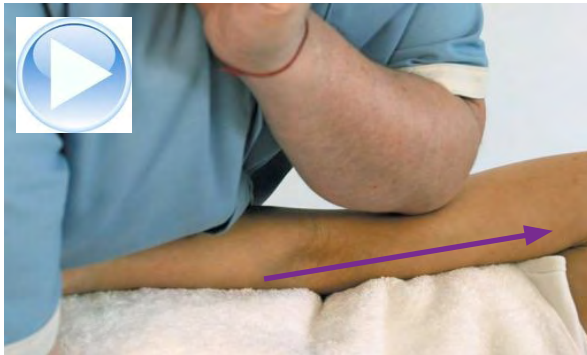
[Click here to play video \(video will open in new browser window\)](#)

ANTERIOR aspect of upper extremity

This is more appropriate for an anterior or lateral presentation.

Here, you might find a tight band towards the front of the outside of the arm.

Trace this band upwards to its origin; this is usually an exquisitely tender spot near the front of the glenohumeral joint. Rest on this spot.



[Click here to play video \(video will open in new browser window\)](#)

Modification using a two-person technique

In Phases II or III, you may want to use a little more force.

To achieve this, you can ask a colleague to distract the arm with sustained pressure while you perform STEP 1.



[Click here to play video \(video will open in new browser window\)](#)

STEP 2 - ANTERIOR/POSTERIOR/LATERAL

As the patient lies on their side, let the upper arm hang off the bed as much as possible.

If this is not possible, try to encourage the patient to let the arm hang down as much as possible. If painful, ask the patient to support the front of the affected shoulder with their other hand. This may be difficult for an acute Phase I case – so do not force the issue. If too acute, focus more on STEPS 4 & 5 anterior.

The following is a KEY STEP for the technique; it should thus be attempted wherever possible (bearing the above in mind).

Now find the trigger point located in the joint capsule. This varies slightly according to patient morphology and thus (postural) change in fascial plane. You should fall into a sulcus in the posterior axilla behind the glenohumeral joint and in the belly of the teres minor muscle. It should feel comfortable for you to rest there.

Use deep, sustained pressure on this point. Ask the patient to breathe in and out slowly, allowing the hand and arm to get heavier and drop toward the floor with the breathing. Instead of pushing, you should rest your weight in a type of comfortable leaning/resting. Feel the tight teres minor muscle under your contact point and wait for a change. Only go deeper if:

You feel the patient can take it; Diabetic or “stuck” patient; Phase III; Large or “dense” muscular male/female; You want to achieve a faster result.

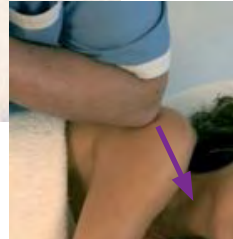
Hold this point for up to three minutes. Sometimes, if the pain eases quickly, you can change your direction of pressure within the zone and hold this spot for a few minutes.

Feel for the fascia and trigger point to release. Allow the patient to relax into the pressure.

DO NOT COME AWAY TOO QUICKLY AS IT CAN INDUCE A SPASM IN THE ARM.



[Click here to play video \(video will open in new browser window\)](#)



Modification - standing in front of the patient

This modification deepens the pressure. Exert it sparingly and NOT in a phase I case until you are sufficiently confident.

[Click here to play video \(video will open in new browser window\)](#)



Modification using two-person technique

In Phases II or III, you may want to use a little more force.

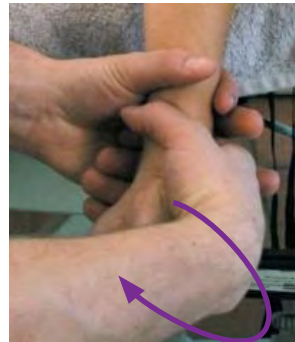
To achieve this, you can ask a colleague to distract the arm downwards towards the floor with sustained pressure while you perform STEP 1.



[Click here to play video \(video will open in new browser window\)](#)

Two-person technique handhold

Hold the downward arm just above the wrist. Internally rotate the arm – locate the trigger point, and then externally rotate the arm while maintaining steady pressure on the trigger point.



STEP 3 - ANTERIOR/POSTERIOR/LATERAL

THIS STEP IS SIMPLE PASSIVE CIRCUMDUCTION

It is important that the patient's arm is completely heavy and relaxed, and that the person performing the technique takes all the weight.

Remember, this is a passive circumduction.

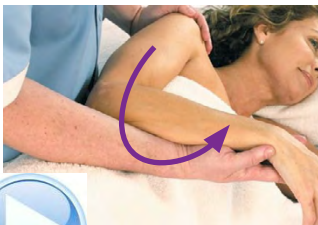
Firstly, after completing STEP 2, gently bring the patient's arm back to their side. The arm may be sore, so go slowly.

Now you are going to move the bent arm in small circles, gradually increasing them to larger complete circles (circumduction).

Take the arm in a clockwise direction.

The aim is to ease the muscle and reorient the muscle spindle and other proprioceptive organs. Remember to take the arm backwards as well. Do not force the arm!

Take it to the pain zone and then come away about 20%. Use slow, confident movements. Keep asking the patient to relax their arm. Do this several times.



[Click here to play video
\(video will open in new
browser window\)](#)



[Click here to play video
\(video will open in new
browser window\)](#)

You should now repeat STEPS 1, 2, and 3 twice more (three times in total).

How do I know when I have done enough?

Each time you return to STEP 1, the nodules of the lateral aspect of the arm should feel softer.

STEP 4 - LATERAL

Remember, this part of the technique is only used if you suspect the following:

- LATERAL presentation
- Subacromial impingement
- Adhesive bursitis
- Superior glide and encapsulation of the glenohumeral joint
- Post-fracture adhesions above the glenoid
- Severely encapsulated shoulder with little or no abduction

Perform at the end of STEPS 1-3 ANTERIOR as a type of follow-on.

Having run up the side of the arm from the elbow region, pausing at the nodules (STEP 1), trace your way to the major LATERAL trigger point at the tip of the shoulder.

This lies directly below the acromion process.

You should literally feel a little ball-like nodule in this region, about the size of a pea.

Here, direct sustained pressure is used just above the ball and socket region (the subdeltoid space).

This is the point into which you should direct your force, directly towards the floor. This is a type of distraction.

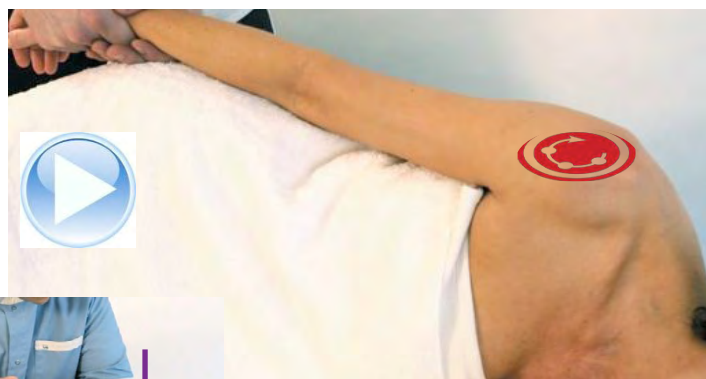
The adhesions lie deep within the joint, beneath the area where you can reach directly.

Hold it for up to three minutes until the pain eases.

In the following circumstances, this sometimes requires quite considerable force:

Severely limited range of motion; Diabetic or “stuck” patient”; Phase III; Large or “dense” muscular male/female; You want to achieve a faster result.

Sometimes the patient reports pins and needles in the hand. Remember the Circumflex Humeral Artery. Come away for a few seconds and then you can try again.



[Click here to play video](#)
(video will open in new
browser window)

When do I treat **LATERALLY**?

As a rule, I tend to work on this point more as the treatment sessions progress. Over the first three to four sessions, I nibble away at the point, perhaps lingering a little longer each time. If other shoulder movements are returning more quickly than abduction, it may be that there is a need to work a little more vigorously into this point. Towards the final sessions, I can spend up to eight minutes on this point alone! Don't forget that in most cases the glenohumeral joint is often "sucked upwards" superiorly to some degree in the frozen shoulder.

Modification with fulcrum

Use a rolled up towel in the axilla to create a counterforce for your pressure.

Then perform STEP 4 LATERAL.



Modification using a two-person technique

In Phases II or III you may want to use a little more force. To achieve this, you can ask a colleague to distract the arm with sustained pressure while you perform STEP 4 LATERAL.



This allows you to really get into the subacromial space.



[Click here to play video](#)
(video will open in new
browser window)

Modification - supine

Here, you can turn the patient on their back – supine. Approaching the LATERAL trigger from this angle can allow you to deepen your pressure. This is often a good technique to use if you are near the end of a treatment and still feel there is more to do in freeing up the LATERAL aspect of the joint.



[Click here to play video](#)
(video will open in new
browser window)

Any more advice for locating and manipulating this point?

If you trace the nodules up the lateral aspect of the arm, you are often led to this point. Be careful not to slip off the point. It can be quite a slippery little point, so be careful not to put too much force on it until you have found the right angle to approach it. If the patient is in late Phase II or Phase III and is severely stuck, you may want to spend considerably longer on this point.

I have been known to spend up to half the (half-hour) treatment session on this point.

This modification is also useful if the patient has extremely reduced abduction or can only abduct in the plane of the scapula.

STEP 4 - POSTERIOR

Turn the patient onto their front.

Gently work all the way up the arm from the elbow to the back of the shoulder joint. You will feel fascia tethering at certain points; work deeper as you approach the back of the joint.

As you get to the posterior axillary fold, you should meet a very tight and painful nodule in the hot zone. This is the major trigger point for the posterior capsule. Use deep, sustained pressure on this nodule. If there is not enough shoulder movement to drop the arm over the side of the bed, you can leave the arm close to the side of the body and perform the release in this position.

(You can also pull the arm slightly for comfort.) This point will probably require pressure for one to three minutes until you feel it soften and the pain reduce.

It may require quite a bit of deep, sustained pressure.

Ask the patient to focus on their breathing and visualize the pain melting away.

Again, when this point “melts away”, you may want to vary the direction of pressure within the point, and then hold it again for up to five minutes until it melts.

It is sometimes difficult for the patient to lie on their front, especially if they are nervous or in Phase I (or both).

Offer reassurance and talk the patient through what you are about to do.

If possible, drop the arm off the bed. This is preferable, but if it is not possible, you can keep the arm straight by the side.



Posterior Trigger Point

[Click here to play video \(video will open in new browser window\)](#)

POSTERIOR - When do I treat the patient prone?

There are several types of occasions when you might consider treating prone:

- With a POSTERIOR presentation
- When a case seemed to be improving but then regresses
- When a case plateaus
- In a severely encapsulated case
- At the beginning of sessions two and three in an acute Phase I case

With a POSTERIOR presentation

These are rare on their own; most often they occur in a combination, especially with the lateral presentation. In POSTERIOR cases, follow this protocol:

- ANTERIOR STEPS 1-3 (three times)
- LATERAL STEP 4 (if appropriate)
- POSTERIOR STEP 4 (prone)

When a case seemed to be improving but then regresses!

This is quite rare but does occur, so be prepared. Here, the patient seems to improve for pain and range of motion over three to four sessions and then they report a “flare-up”. My hypothesis is that the inflammation has “burnt itself out” at the front of the capsule/biceps tendon, but has migrated to the posterior inferior capsular fold – in between two heads of the biceps.

When a case plateaus

As above, if you are struggling with a case, you may want to employ all of the techniques available to you. I would recommend the following combination:

- POSTERIOR (prone)
- ANTERIOR STEPS 1- 3
- LATERAL STEP 4
- ANTERIOR STEPS 4 & 5

In a severely encapsulated case

- POSTERIOR (prone)
- ANTERIOR STEPS 1-3
- LATERAL STEP 4
- ANTERIOR STEPS 4 & 5

At the beginning of sessions two and three in an acute Phase 1 case

With the patient prone, work deeply into the posterior axillary fold. Find the tough and painful trigger point and hold it. You will need to work in small but increasing circles deep into the capsule as it lies between two of the triceps' heads and local knotted muscles. The idea is to work on the chronic inflammation as it pools in this area. This can be an extremely painful component of the technique.

Please DO NOT attempt prone treatment until you feel competent with the technique.

Modification - patient supine

In a severely encapsulated POSTERIOR presentation, there is more you can do! Similarly to STEP 5 anterior, you can accurately reproduce the triceps pain component:

Turn the patient onto their back.

Gently work in to the anterior chest wall. You will feel a trigger point (fascial tethering) in the region of the pectoralis minor; this point is near the short head of the biceps insertion (coracoid process). Working deeper as you approach the point, you may need to generate quite some force.

This is a secondary trigger point for the posterior capsule. Use deep, sustained pressure on this nodule.



Pressure here should accurately reproduce pain in the POSTERIOR aspect of the capsule and slightly down the arm into the triceps. This point will probably require pressure for one to three minutes until you feel it soften and the pain reduce.

It may require quite a bit of deep, sustained pressure.

Modification - patient prone, coming from the other side

Approaching the trigger point from another angle may just give you an advantage for deepening the effect. I am often surprised by the large difference in effect that such a simple change can produce.

Turn the patient onto their front.

Approach the posterior axillary fold from the other side, you should meet the subscapularis tendon and the POSTERIOR hot zone – trigger point.

This is the major trigger point for the posterior capsule. Use deep, sustained pressure on this nodule.

If there is not enough shoulder movement to drop the arm over the side of the bed, you can leave the arm close to the side of the body and perform the release in this position.



[Click here to play video
\(video will open in new
browser window\)](#)

(You can also pull the arm slightly for comfort.) This point will probably require pressure for one to three minutes until you feel it soften and the pain reduce.

It may require quite a bit of deep, sustained pressure.

STEP 4 - ANTERIOR (POSTERIOR AND LATERAL)

This is a direct technique

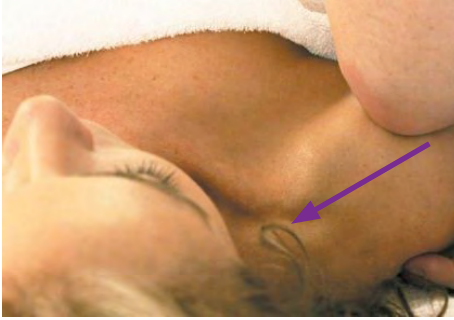
With the patient on their back, work slowly up the top of the biceps towards the long head of the biceps tendon. Move towards the head only.

Pause on the nodules which occur as “ruffles” along the tendon sheath, a source of chronic inflammation. You will find approximately three or four.

As you approach the shoulder, you should feel a particularly tender point. This is where the biceps tendon makes a right turn (under the transverse ligament) on its way to the capsule; I often find the fascia to be particularly thickened at this point.

Hold this trigger point for up to three minutes until it is completely pain free. Do not come away early as this may trigger a spasm.

I use my elbow for comfort, but you can use your thumbs if you like - just go slowly and carefully.



[Click here to play video](#)
[\(video will open in new browser window\)](#)

Run up the LHB with very slow, deep, stroking massage, and pause on the nodules on the way up towards the transverse ligament



Pause at or around the transverse ligament

STEP 4 - ANTERIOR/POSTERIOR/LATERAL - Modifications

Advice for approaching the LHB tendon

Go slowly and feel your way up the tendon sheath. Pause on the packets of chronic inflammation. You may get a rumbling sound from the stomach, especially as the area improves; this reliable finding can actually be used diagnostically.

Central bowstringing

Find the middle of the LHB and work along it up to the top of the humerus.

BE CAREFUL NOT TO SLIP OFF!



Lateral bowstringing

Working from the outside (lateral) border of the LHB, gently bowstring the tendon inwards, pausing at the nodules.



[Click here to play video](#)
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browser window)

Medial bowstringing

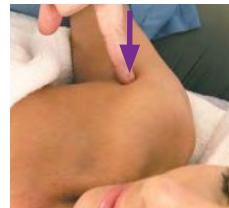
Working from the inside (lateral) border of the LHB, gently bowstring the tendon outwards, pausing at the nodules.



[Click here to play video](#)
(video will open in new
browser window)

Working in between the long head biceps (LHB) and the short head biceps (SHB)

Occasionally there is a useful trigger point between the LHB and the SHB. If you find this point, you can nestle down into the point for up to five minutes.



[Click here to play video](#)
(video will open in new
browser window)

STEP 5 - ANTERIOR/POSTERIOR/LATERAL

This is an indirect technique

With the patient supine, use the middle fingers of your hand to press deeply on the trigger point in the hot zone in the middle of the shoulder blade (infraspinatus/teres minor).

Use deep, sustained pressure on this point.

You can reinforce the finger with your other hand.

Be careful with your own wrist position and make sure it is well supported.

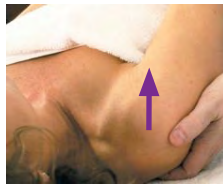
This can be extremely painful, so ease into it, moving clockwise around the zone until the pressure on this point exactly reproduces the patient's symptoms "inside" the shoulder joint.

Hold this for up to five minutes with sustained pressure, until the point relaxes and is no longer painful (this may take a while).

If you get the right spot, the patient should feel referred pain in the front of the shoulder (biceps area).



[Click here to play video](#)



[Click here to play video](#)



Frequency of treatment and expectations

Use the following as a guide:

Phase I

Once a week for three weeks, then fortnightly, then once every three weeks. This should take three to five sessions to lessen the inflammation (measured by less or no night pain), followed by five to seven sessions to regain the range of motion.

Phase II

Once a week for three weeks, then fortnightly for three sessions, then monthly, or more often (every three to four days) if required.

This should take three sessions to lessen the inflammation (measured by less or no night pain), followed by three to five sessions to regain the range of motion.

Phase III

Once a week for three to five sessions, or more often (every three to four days) if required. This should take three to five sessions.

As a rule, 85% of cases can be treated in less than eight to ten sessions.

Niel-Asher Technique - FAQ (Part 1)

What handhold do I use?

I use my elbow for treating the pressure points. This is because it allows me to generate more force. This is something that you can try, but at the beginning you may tend to slip – so go slowly. You can try using your thumb reinforced with your other hand behind it.

How much pressure (FORCE) do I use?

This is something that comes with experience, but as a rule of thumb, the more painful the tissue, the slower and deeper the pressure. In all cases the key words are “work slowly and thoroughly.” Another factor that determines the amount of force you should apply is the muscle type (red/white fiber) and morphology of the patient. This will affect the depth of treatment. If the patient is “stocky,” I would expect to have to work quite vigorously, especially into the posterior capsule. If they are slight, you won’t need to use as much force to affect a change in the tissues.

How fast do I go in STEP 1 (VELOCITY)?

This depends somewhat on what you want to achieve. Varying the speed of the stroke can do the following:

Faster – is more stimulatory, and it is especially useful in a Phase III treatment or in general in the last few treatment sessions to “ramp up” abduction.

Slower and deeper – is more useful for the stubborn, stuck, or diabetic shoulder.

What is the direction of force?

This is an interesting question. I have tried wherever possible to indicate the direction of force on the pictures. The direction of force varies slightly from person to person. In general, the aim is to reproduce the painful symptom, so for instance, when you find the painful nodules and with a change in sustained pressure or direction of force, see the effects that this has on the pain. It often amazes me that a slight change in the direction of the pressure can cause a totally different pain elsewhere. We want to find the direction of pressure that, where possible, reproduces the exact pain that the patient feels (see hot zones module 1).

Bruising!

Bruising should not occur if you follow the instructions. I have found that it is not the depth of treatment that will cause a bruise; it is usually that it is done too quickly. Try to feel the muscles and tender nodules beneath the skin. Arnica creams and tablets have been shown to reduce the incidence and severity of bruising.

It is important to warn a patient that bruising may occur if they are on warfarin or another blood-thinning medication.

Notes:



Niel-Asher Technique - FAQ (Part 2)

What is fascia?

This is an important structure that I believe is worth spending a few moments on. Superficial fascia is also known as connective tissue; it is a clear, fibrous tissue. It is modified according to where it is in the body (superficial or deep), but it is somewhat like “cling wrap.” If you eat chicken, you may well be aware of the superficial fascia. It lies under the skin and is a tough, transparent (cling wrap-like) tissue layer.

In fact, mammals are not the only organisms to have fascia. It abounds in plant life as well. Here, it is often not a tough, clear layer (although it is the clear stuff that lies in between onion layers) but is often dense and white; we call it pith. To explain fascia to my patients, I find it easier to think of oranges. In an orange, the skin is a modified layer of fascia, and below the skin surrounding the segments is the white pith; this is also fascia. The segments of the orange are clear bag-like structures; these are also fascial. Then if you look carefully, the juice is held in tiny bags; again, these are also fascial. So fascia is ubiquitous; it covers, surrounds, and supports our organs, and it covers the muscles and acts as the “packing tissue” throughout the body. The capsule of the shoulder joints and ligaments are also constructed from fascia. Even bone is (essentially) fascia that has become impregnated with calcium, potassium, and magnesium salts.

Superficial and Deep Fascia

The fascia we are interested in is superficial; it invests the muscles like an envelope. It is plastic-like; when it is injured or damaged, it becomes shorter, condensed, and tighter. This is what gives it the nodular feel underneath the skin.

These nodules are the trigger points

In both chronic and acute shoulder pain, much of the fascia begins tightening. Fascia condenses around the point where it is damaged and drags other fascial fibers with it (see diagram below). Fascia “shrink-wraps” various structures; the inflamed capsule tightens and its investing fascia tenses, especially where there is muscle wasting. Lack of use fuels this fascial condensation, and this is all the more so in the diabetic frozen shoulder, or chronic frozen shoulder. There may be a deal of underlying fascial tightening in all shoulder structures, especially in long-standing cases. NB: Starting at the age of 30, wear and tear of all shoulder structures can be clearly seen by imaging; this is before almost any other joint (owing mainly to the degree of flexibility of the glenohumeral joint and the amount we use our shoulders, arms, and hands).



Concept of Superficial Fascial Warping - c/o Ida Rolf

Notes:



Niel-Asher Technique - FAQ's (Part 3)

What Equipment do I need?

UP/DOWN treatment couch (optional) preferably with face-hole (optional).
Cushion for face. Foam wrist support.

Models of shoulder (optional). Goniometer.

Creams (BLUE NIVEA™). Exercise programme sheets. Resistance exercise bands. Clinical testing equipment.

What creams or lotions should I use?

In general, it is better to avoid oils as they may cause you to slide off from the pressure points once you have found them. I use plain blue 'Nivea®™' cream. Alternatively, you may use:

Arnica cream

Plain Aqueous cream (with a few drops of vitamin E – food quality oil)
Petroleum Gel

Massage oils/liniments

NB: always ask if you or your patient has a Lanolin allergy, or an allergy to any of the above.

NB: be aware of any open skin wounds or skin lesions before applying creams or lotions.

Notes:



Niel-Asher Technique - FAQ (Part 4)

Does the treatment stop the frozen shoulder?

In an early Phase I case without massive inflammation, the answer is 50:50.

It is my experience that little can be done to stop a frozen shoulder developing once the process has started in earnest.

The treatment I am proposing seems to accelerate the condition through its phases rather than stop it in its tracks.

Steroid injections?

This is discussed elsewhere. In about 5%-10% of phase I cases, I recommend one or a series of (up to four) local steroid injections into the front and back of the joint.

For those of you who are against this type of intervention, patients should not need this. Practically speaking, however, some patients are in so much pain (due to the massive amounts of inflammation) that it may be more expedient in some cases to follow this route – you must use your own discretion.

What would be my course of action if the patient had not improved?

This depends on the phase at which the patient presents. If they are in phase I and in a lot of pain and:

- If there is no change after five sessions
- If the night pain is still extremely severe

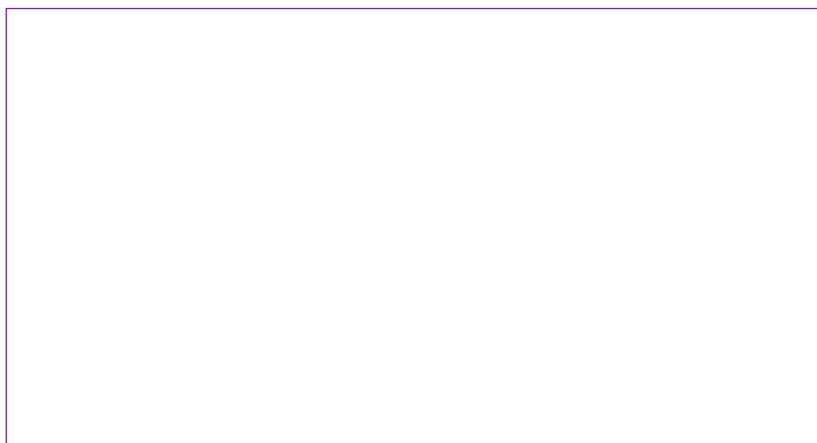
First, I would thoroughly explain the natural history and pathogenesis of the condition. This is to put the patient at ease as much as possible; remember, they are scared and often in very bad pain.

Then I would refer them to a colleague (orthopaedic physician) for further investigation and/or steroid injection. If investigations, etc., were NAD (No Abnormalities Detected), I would continue with my treatment programme. If the (night) pain was still extremely severe, I might refer the patient for either a course of amitriptyline or a suprascapular nerve block (guanethidine); this has happened only three times in over 450 patients. I have, thankfully, never needed to recommend manipulation under anaesthetic (MUA).

I have found that working deeply into the posterior capsule with the patient prone can also speed up a Phase I problem. The aim is to stimulate a small, localized, acute, inflammatory reaction in the posterior part of the capsule. This purges the chronic inflammatory cascade.

Note: This can be very painful for the patient and should not be done until you are comfortable and familiar with the technique.

Notes:



Niel-Asher Technique - FAQ (Part 5)

Is there a pattern in which mobility returns?

Yes. This depends on the phase and/or presentation (A/P/L). As a rule, simple movements come back first. That is why we measure “pure” simple passive ROM. Complex movements should start to return after this:

- From the 8th session - Pre-Phase I / Phase II
- From the 5th session - Phase II
- From the 3rd session - Phase III

More complex movements return as flexion hits about 140°. As a rule, most people can “live with” any movement over and above 150°, although your aim should always be to get the movement back as quickly as possible.

Please note the following:

Slow to return extension and external rotation would indicate a binding in the ANTERIOR capsule.

- Biceps tendonitis LHB. Anterior capsule. Biceps tendonitis SHB.

Slow to return abduction might indicate a LATERAL capsular pattern:

- Adhesive bursitis. Underlying RCT.
- Underlying impingement syndrome.

Slow to return flexion might indicate binding in the POSTERIOR capsule.

- Triceps tendonitis.
- Inflammation “slipping” to the back of the joint.

Notes:



Niel-Asher Technique - FAQ (Part 6)

My patient is complaining that they still can't reach behind their back. How can I increase the range of motion for getting the arm up behind the back (APLEY)?

The APLEY maneuver is always the “last to return.” There is a very potent trigger point in the biceps belly that can accelerate a return for this movement pattern. Ideally, this should be used towards the end of the treatment cycle, once the range of motion is above 160° flexion.

As a result of the LHB inflammation, the whole of the biceps muscle becomes shortened and fibrotic. In my opinion, this is the major limiting factor for internal rotation and the APLEY maneuver.

Inhibition to the trigger point in the biceps belly rapidly increases the APLEY range of motion.

Biceps Belly Technique

With the patient on their back, slightly flex the arm.

Working slowly and gently, find the trigger point in the middle of the biceps belly. This is usually about four fingerbreadths above the fold of the elbow.

Pause on this nodule.

Hold this trigger point for up to five minutes until it is completely pain free.

Find the trigger point and move slowly to another area “within it” once one area of the trigger point has fatigued (see hot zones).

Do not come away early as this may trigger a spasm.

I use my elbow for comfort, but you can use your thumbs if you like - just go slowly and carefully.



Notes:**Advice to Practitioners (Part 1)****Before you start treating, please read the following:**

Make sure the patient is in control, and let them know they can tell you to stop at any time.

What not to do:

Never jerk the arm.

Never force the arm beyond its natural boundary.

Do not come away from a trigger point too quickly as this may trigger a spasm.

N.B.

The treatment can be painful, especially in the early days. It is essential that you communicate this effectively, and tell the patient what you are doing. I usually say, “Treatment can be painful, but is usually no worse than a frozen shoulder.” Don’t forget, you are not going to be “forcing” the shoulder in any direction!

You must always tell the patient that they are in control and that they can say stop at any time. If you are in the middle of a trigger point procedure, do not come away too quickly as this can lead to an acute spasm.

Be Brave!

When you first start using the technique, you might be afraid, especially if the patient is in a great deal of pain. Please be assured, it really does work. Stick to the instructions given. After treating a few cases, you will get the hang of it. Also, there is no substitute for experience, so review the modules regularly at first, and go gently. You can build up force as you get more skilled at the technique.

Notes:

Advice to Practitioners (Part 2)

Before you start treating please read the following:

Pain thresholds!

Patients have different pain levels/thresholds, and this has to be taken into account. One of the facts about FS is that it occurs in patients with lower pain thresholds. This may be due to the fact that they are more frightened to move the injured arm; thus it seems to “freeze” more quickly.

Further advice!

Patient might benefit from using ice and heat at night on the front of the shoulder (region of the biceps tendon) before they go to sleep.

On no account should the patient stop using or splint the arm; if anything, he should be encouraged to do daily ROM exercises.

Treatment Reactions / Side Effects

The majority of people (70%) have a reaction to treatment after an osteopathic session. Treatment reactions are a natural part of the overall effect of osteopathy. We have become accustomed to going to the doctor and receiving a pill or remedy, which usually works within a few hours.

Osteopathy seems to work differently. Osteopathy taps into the body's own healing mechanisms, and these often take a few days to adjust and rebalance. Curiously, from research it seems that the worse the treatment reaction, the better the improvement that seems to follow it! (JACM April 1997 & June 1997)

Some common treatment reactions/side effects:

Tiredness

Soreness (localized)

Changes in bowel movement (diarrhea or constipation)

Increased urinary frequency

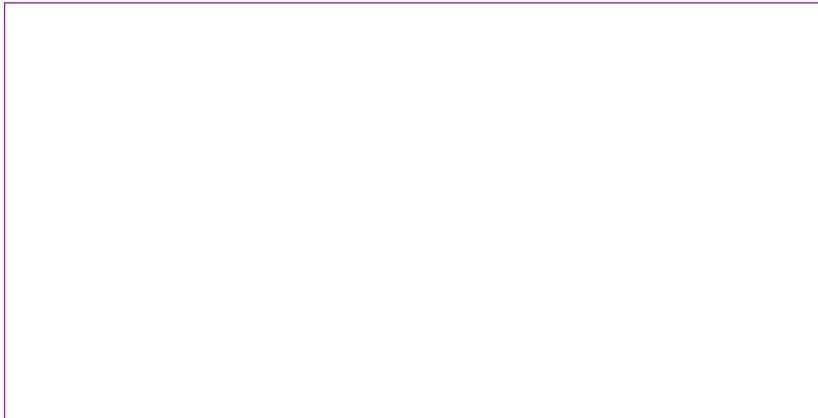
Joint aching (“flu-like”) and/or increased pain for about 24-48 hours

Some people feel emotional, vulnerable, and/or tearful

N.B.: A treatment reaction commonly lasts for two to three days

N.B.: Tell your patient to drink plenty of water after treatment and rest when possible.

Notes:



Structuring appointments (sequences)

How do I structure a typical appointment?

In my clinic, I spend half an hour per session. This is for the first session and each subsequent session. I will attempt to take you through typical treatment session sequences for unilateral and bilateral presentations; I will give you an indication of the time each STEP might take. We will also explore the nuance and variation at different stages in the treatment cycle.

We will now explore how to put together a treatment plan for various scenarios.

These sequences are for your reference. Take your time, and read each sequence carefully, as they will form the basis of your own future work in this field.

The key is to move efficiently from one maneuver to another; the more familiar you are with these sequences, the better. I work from a half-hour list and have tailored my treatment programs accordingly. Depending on the severity and chronicity of a case, you may find each treatment can be performed within 20-35 minutes.

Frequency of treatment and expectations

Phase I

Once a week for three weeks, then fortnightly, then once every three weeks. This should take three to five sessions to lessen the inflammation (measured by less or no night pain), followed by five to seven sessions to regain the range of motion.

Phase II

Once a week for three weeks, then fortnightly for three sessions, then monthly, or more often (every three to four days) if required.

This should take three sessions to lessen the inflammation (measured by less or no night pain), followed by three to five sessions to regain the range of motion.

Phase III

Once a week for three to five sessions, or more often (every three to four days) if required. This should take three to five sessions to lessen the inflammation (measured by less or no night pain), followed by three to five sessions to regain the range of motion.

As a rule, 85% of cases can be treated in less than eight to ten sessions.

Notes:



First Treatment Session

How do I structure a typical appointment?

The first session really is the most important. You need to obtain vital information from the case history in an efficient and effective manner. You need to earn the patient's confidence; this can be done through a thorough and well-rehearsed case history – because the questions you ask will reassure the patients that you know what they are going through. You need to explain the technique, and you need to introduce your hands to the patient.

Remember, patients are often in a great deal of pain, so you need to explain everything as you go along.

N.B.: You also need to obtain consent.

Pre-Phase I

You are most likely to see a phase 0-I presentation in patients who have seen you before with a previous frozen shoulder. This is because they know the signs. In such a case, the patient may not have lost all mobility; in fact, they may have almost all of their range of motion. As discussed previously, there is a 50/50 chance of “nipping” the frozen shoulder in the bud. In the other cases, you can “speed” the shoulder through its course – the key diagnostic difference between these is the time elapsed since onset and the amount of inflammation in the joint.

Exercise

You should consider the prescription of exercise very carefully. The very stiff patients seem to need little or no strengthening rehab to get back their power, but those patients whose range of motion returns dramatically may well benefit from strengthening/band work.

Notes:



Unilateral Frozen Shoulder

Typical Phase 0-I Unilateral Sequence

Consent form is given to patient before treatment begins. Case history: 10-15 minutes.

Examination/goniometry/special testing: five minutes (includes consent form).

Explanation of diagnosis & treatment: one to two minutes (if it is a bad case or if there is a suspected underlying rotator cuff lesion – please be honest with the patient). See frequency chart below.

Start sitting treatment: two minutes (here I introduce the idea of relaxing into the trigger point with breathing).

Either:

STEP 1 ANTERIOR }

STEP 2 ANTERIOR } (once only): two to three minutes. Do not test arm range of motion.

STEP 3 ANTERIOR }

STEP 4 ANTERIOR }

STEP 5 ANTERIOR } (once only): two to three minutes. Do not test arm range of motion.

Or

STEP 4 ANTERIOR }

STEP 5 ANTERIOR } (once only): five-six minutes (if you suspect the biceps tendon is very acute). Do not test arm range of motion.

Typical Phase II Unilateral Sequence

Consent form is given to patient before treatment begins. Case history: 10-15 minutes. Examination/goniometry/special testing: five minutes (includes consent form).

Explanation of diagnosis: one to two minutes (tell the patient how many sessions are required).

Start sitting treatment: three minutes (here I introduce the idea of relaxing into the trigger point with breathing).

STEP 1 ANTERIOR }

STEP 2 ANTERIOR } (once only)

STEP 3 ANTERIOR }

STEP 4 ANTERIOR }

STEP 5 ANTERIOR } (once only) Test arm range of motion carefully again.

Patient dresses.

Retest range of motion.

N.B.: Even after this short session, there should be some change in range.

Typical Phase III Unilateral Sequence

Consent form is given to patient before treatment begins. Case history: 10-15 minutes.

Examination/goniometry/special testing: five minutes (includes consent form). Explanation of diagnosis: one to two minutes. Start sitting treatment: three minutes (here I introduce the idea of relaxing into the trigger point with breathing).

STEP 1 ANTERIOR }

STEP 2 ANTERIOR } (once only)

STEP 3 ANTERIOR }

STEP 4 ANTERIOR }

STEP 5 ANTERIOR } (once only) Test arm range of motion carefully again.
Patient dresses.

Retest range of motion.

N.B.: Even after this short session, there should be some change in range.

Bilateral Frozen Shoulders – Sequence First Treatment

It's important to be even more time efficient with your first session of a bilateral case. If you feel you cannot do justice to a case in the time allotted, just focus on the acute shoulder in the first instance. For this, see the protocol above. As you get more proficient, you may want to follow the protocol below:

Typical Phase 0-I Bilateral Sequence

Consent form is given to patient before treatment begins. Case history: 10-15 minutes. Examination/goniometry/special testing: five minutes (includes consent form).

Explanation of diagnosis & treatment: one to two minutes (if it is a bad case or if there is a suspected underlying rotator cuff lesion – please be honest with the patient). See frequency chart below.

Start side-lying treatment immediately with patient on less acute side first.

STEP 1 ANTERIOR }

STEP 2 ANTERIOR } (once only): two to three minutes

STEP 3 ANTERIOR }

Switch sides and repeat two to three minutes.

STEP 4 ANTERIOR }

STEP 5 ANTERIOR } (once only): two to three minutes. Do not test arm range of motion.

Switch sides and repeat two to three minutes.

Or

STEP 4 ANTERIOR }

STEP 5 ANTERIOR } (once only on the acute side): five to six minutes (if you suspect the biceps tendon is very acute). Do not test arm range of motion.

Or

STEP 4 ANTERIOR }

STEP 5 ANTERIOR } (once only): five to six minutes (if you suspect the biceps tendon is very acute)

N.B.: Do not test arm range of motion.

Typical Phase II-III Bilateral Sequence

Here, the most common presentation is one Phase III shoulder and one Phase I or II. You will notice that this is a similar sequence to the Phase II Bilateral.

Consent form is given to patient before treatment begins. Case history: 10-15 minutes. Bilateral Examination/goniometry/special testing: five to six minutes (includes consent form).

Explanation of diagnosis & treatment: one to two minutes (if it is a bad case or if there is a suspected underlying rotator cuff lesion – please be honest with the patient). See frequency chart below.

Start side-lying treatment immediately, with patient on less acute side first.

STEP 1 ANTERIOR }

STEP 2 ANTERIOR } (once only): two to three minutes

STEP 3 ANTERIOR }

Switch sides and repeat two-three minutes.

STEP 4 ANTERIOR }

STEP 5 ANTERIOR } (once only): two to three minutes. Switch sides and repeat the above steps for two to three minutes. Retest arm range of motion at the end of the session.

Or

STEP 4 ANTERIOR }

STEP 5 ANTERIOR } (once only on the acute side): five to six minutes (if you suspect the biceps tendon is very acute)

Patient dresses.

Retest arm range of motion.

N.B.: Even after this short session, there should be some change in range.

Second - Fourth Treatment Sessions

Here, you are really starting treatment in earnest. The technique starts to “kick in” during these sessions. Remember what we said about the technique reprogramming the cortex. Be consistent in your use of the technique, as each session neurologically reinforces the one before. The patient may be sore from the previous session but should feel an improvement. It is important to reinforce this positive message to the patient. Tell them not to give up and that they are “in process”. These are very important sessions. Even if you can not see an immediate change, keep with the treatment as the changes may be going on internally!

Although you should have made your mind up on a diagnosis, you can always change it if more information becomes available. Keep your mind flexible about the patient’s condition.

Sometimes the pain can move from front to back – this is important as we discussed in POSTERIOR STEP 4 (module 2). More of this later.

Unilateral Frozen Shoulder

Typical Phase 0-I unilateral - Sessions two-four

Ask questions about changes in pain, sleep, or range of motion: two to three minutes.

Reassurance if needed; explain that the 1st session is a mainly diagnostic with some treatment, but from here on in it is “all treatment”: one to two minutes.

Re-examination/goniometry/special testing (you may change the diagnosis if you think you were wrong!): four minutes. Start sitting treatment: two to four minutes (Don’t forget the idea of “relaxing into the trigger point with breathing”).

Either:

STEP 1 ANTERIOR }

STEP 2 ANTERIOR } (three times): two to three minutes

STEP 3 ANTERIOR }

STEP 4 LATERAL (optional)

STEP 4 POSTERIOR - “Experienced or Advanced practitioners” only: five-six minutes (optional)

STEP 4 ANTERIOR }

STEP 5 ANTERIOR } (once only): five to eight minutes. Gently retest arm range of motion.

Or

STEP 4 POSTERIOR (once only): 15 minutes - note - see above.

STEP 4 ANTERIOR }

STEP 5 ANTERIOR } (once only): 10-15 minutes (if you suspect the biceps tendon is very acute). Do not test arm range of motion.

N.B.: Do not test arm range of motion.

Typical Phase II and Phase III unilateral sequence - Sessions two-four

Ask questions about changes in pain, sleep, or range of motion: two to three minutes.

Reassurance if needed; explain that the first session is a mainly diagnostic with some treatment, but from here on in it is “all treatment”: one-two

minutes. Re-examination/goniometry/special testing (you may change the diagnosis if you think you were wrong!) four minutes. Start sitting treatment: two-four minutes (Get the patient to work the trigger point by relaxing deeply and using breathing).

STEP 1 ANTERIOR }

STEP 2 ANTERIOR } (three times): two to three minutes

STEP 3 ANTERIOR }

STEP 4 LATERAL (optional)

STEP 4 ANTERIOR }

STEP 5 ANTERIOR } (once only) Test arm range of motion carefully again.

Patient dresses.

Allow a few minutes (perhaps in the reception area). Retest range of motion with patient clothed – this engenders reassurance.

N.B.: Even after this short session, there should be some change in range.

Bilateral Frozen Shoulder

Typical Phase 0-I, Phase II and Phase III Bilateral Sequence – Sessions 2 to 4

Again, you are most likely to see one shoulder in Phase III and the other in phase 0-1, although I have seen the bilateral Phase I presentation (rare). In such cases, reassurance and proficiency of technique are key. You may also want to think about the use of steroid injections.

For both shoulders, ask questions about:

Changes in pain, sleep, or range of motion: two to three minutes.

Reassurance is often needed: explain that the first session is a mainly diagnostic with some treatment, but from here on in it is “all treatment”: one to two minutes.

Re-examination/goniometry/special testing (you may change the diagnosis if you think you were wrong!): four-six minutes.

Sitting treatment to loosen up the neck and shoulder muscles. You should measure the least painful shoulder first.

You may not want to measure the more acute shoulder, as it may not benefit from being forced into the extremes even in passive motion.

Start sitting treatment: two-four minutes (don't forget to work the trigger point with the patient focusing on the breathing).

Either:

On good or better side:

STEP 1 ANTERIOR }

STEP 2 ANTERIOR } (three times): two to three minutes

STEP 3 ANTERIOR }

Switch to worse side then

STEP 1 ANTERIOR }

STEP 2 ANTERIOR } (three times): two to three minutes

STEP 3 ANTERIOR }

STEP 4 POSTERIOR prone – “Experienced or Advanced practitioners” only: five to six minutes (optional). Bilaterally on least painful shoulder first.

Turn patient onto their back:

STEP 4 ANTERIOR }

STEP 5 ANTERIOR } (once only): five to eight minutes. Better side first.

Or

STEP 4 POSTERIOR – prone – good side first (once only): 15 minutes

Note – be very careful with an acute Phase 0-I.

Some patients don't like lying on their front.

Some patients are scared to lie prone because they are not sure how to get on their front - you must use your own initiative in this scenario.

Patient Supine: Good shoulder

STEP 4 ANTERIOR }

STEP 5 ANTERIOR } (once only): 10-15 minutes (if you suspect the biceps tendon is very acute)

Repeat on more acute shoulder.

Retest arm range of motion, good side first.

Notes:

Fifth, Sixth, & Seventh Treatment Sessions

By now the pain should have gone in all but the most severe Phase I cases.

If the pain is not gone, you should definitely consider a steroid injection! I am personally against these, but remember, your patient always comes first! So, even though this treatment works time and time again, keep all options open. It may also be that there is another pathology underlying the frozen shoulder, such as a rotator cuff lesion or an impingement syndrome. In these cases, it is always best to “defrost” the shoulder as quickly as possible. Please send your patient for an MRI or an ultrasound if you suspect any underlying pathology.

The speed at which the patient recovers is your guideline for the amount of force and velocity required. By now you should have built up a good relationship with your patient, and you should also have an appreciation of their pain tolerance and thresholds. If the case is stubborn, you may want to use more force, or perform the two-person techniques. Don't forget, each time you repeat this treatment, you reinforce a new and more appropriate neurological pathway.

During these sessions, you should start to think about the neck, elbow, wrist, and hand, particularly if the patient is recovering quickly.

Don't forget that the neck muscles have been “heaving” the shoulder joint; you may want to start with a good manipulative soft tissue “work out” of the neck and shoulder.

I also use osteopathic high velocity thrust (HVT) manipulation at this juncture.

You may want to look at the spine, thorax, and posture if the patient is round-shouldered. Although we have found that performing the ANTERIOR technique really seems to help with this.

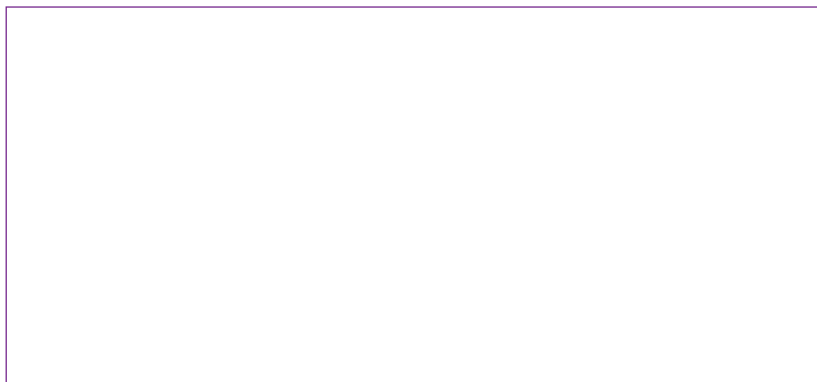
Patients often “overuse and misuse” the wrist flexors and extensors; this is a response to the stiff shoulder – at the very least, this may result in muscular pain and tenderness around the elbow joint. If severe, there may be a golfer’s or tennis elbow.

Some frozen shoulders may come on after RSI and/or tennis/golfer’s-elbow or a wrist problem. Now is the time to focus on these issues. Occasionally I suspend treatment for the frozen shoulder at this point, and dedicate one or two sessions to the above.

My criteria for this is: if the frozen shoulder was secondary to the above and if progress in range of motion plateaus.

Sometimes the pain can move from front to back – this is important as we discussed in STEP 4 Posterior – (module 2). More on this later.

Notes:



Unilateral Frozen Shoulder

Typical Phase II and Phase III unilateral sequence - Sessions 5 to 7

Ask questions about changes pain, sleep, or range of motion: two to three minutes.

Reassurance if needed, especially complex, diabetic, or severely encapsulated patient. Re-examination/goniometry/special testing: four minutes.

Start sitting treatment: three to six minutes (Get the patient to work the trigger point by relaxing deeply and using breathing).

Treat neck, elbow, wrist, and/or hand where appropriate (optional).

STEP 4 POSTERIOR (optional)

STEP 1 ANTERIOR }

STEP 2 ANTERIOR } (3 times) - (optional)

STEP 3 ANTERIOR }

STEP 4 LATERAL (optional)

STEP 4 POSTERIOR – prone – [if not performed at start of treatment]
(optional)

STEP 4 ANTERIOR }

STEP 5 ANTERIOR } (once only)

Biceps belly technique – (see above) for regaining APLEY: up to 5 minutes.

Test arm range of motion carefully again.

Patient dresses.

Allow a few minutes (perhaps in the reception area). Retest range of motion with patient clothed – this engenders reassurance.

N.B.: After this session, there should be some change in range.

Notes:



Bilateral Frozen Shoulders

Typical Phase 0-I, Phase II and Phase III bilateral sequence – Sessions 5-7

Again, you are most likely to see one shoulder in Phase III and the other in Phase II (by now).

For both shoulders, ask questions about changes in pain, sleep, or range of motion: two to three minutes.

Re-examination/goniometry/special testing: three to four minutes.

You should measure the least painful shoulder first, with a sitting treatment to loosen up the neck and shoulder muscles.

You may not want to measure the more acute shoulder, as it may not benefit from being forced into the extremes even in passive motion.

Start sitting treatment: two to four minutes (don't forget to work the trigger point with the patient focusing on the breathing) Treat neck, elbow, wrist, and/or hand where appropriate (optional).

Either:

On good or better side:

STEP 1 ANTERIOR }

STEP 2 ANTERIOR } (three times): two to three minutes (optional)

STEP 3 ANTERIOR }

Switch to worse side then

STEP 1 ANTERIOR }

STEP 2 ANTERIOR } (three times)

STEP 3 ANTERIOR }

STEP 4 POSTERIOR prone – “Experienced or Advanced practitioners” only: five to six minutes (optional). Bilaterally on least painful shoulder first.

Turn patient onto their back: STEP 4 ANTERIOR }

STEP 5 ANTERIOR } (once only): five to eight minutes. Better side first.
Biceps belly technique – (see above) for regaining APLEY: up to five minutes.

Or

STEP 4 POSTERIOR – prone – good side first (once only): 15 minutes.
Some patients don't like lying on their front. Some patients are scared to lie prone because they are not sure how to get on their front; you must use your own initiative in this scenario.

Be careful when lifting the treated arm back onto the bed as it can induce spasm.

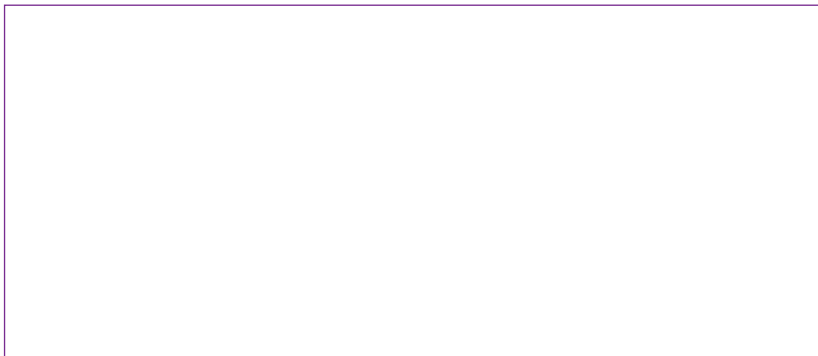
Patient Supine: Good shoulder

STEP 4 ANTERIOR }

STEP 5 ANTERIOR } (once only): ten to fifteen minutes (if you suspect the biceps tendon is very acute). Repeat on more acute shoulder.

Retest arm range of motion, good side first.

Notes:



Eighth Treatment Session and Beyond

By now many of the Phase II and III patients should either be better or well on the way to resolution; in these cases you should stick to the program set out above in the fifth, sixth, and seventh sessions. Even the Phase I cases should be “out of pain” and demonstrate increasing mobility.

If this is not the case, I strongly suggest you review the patient either with a second opinion from a colleague or through further investigations (x-ray, ultrasound, etc.) to rule out any other pathology. Exceptions to the above might include:

Diabetic patient

Complex patient (i.e., frozen shoulder and rotator cuff)

Intractable pain patient – perhaps consider referral to a pain management clinic! Severely encapsulated patient

Post-fracture rehabilitation

Post-breast reconstruction rehabilitation

Bilateral cases where the first frozen shoulder is improved but the other one is still in Phase II

The main issue that most patients have at this point is getting their hand up behind the back (APLEY) or stiffness at the end of range (especially abduction). With this in mind, I have set out various treatment protocol scenarios for the eighth session onwards.

Advice: “Deep and Slow”

By now you should have established a good rapport with your patient. Their pain should be significantly diminished and their range of motion

improving each session. With the difficult cases you have two options; keep working slowly and gently, or using a bit more force into the stiff tissues. This is “your call”, and has to be discussed with the patient and clearly explained. Don’t forget, the deeper you go, the slower you have to be.

Unilateral Frozen Shoulder

Typical Phase II and Phase IV unilateral sequence - Session 8 onwards

Protocol:

Ask questions about changes in pain, sleep, or range of motion: two to three minutes.

Reassurance if needed, especially complex, diabetic, or severely encapsulated patient. Re-examination/goniometry/special testing: four minutes.

Start sitting treatment: three to six minutes (Get the patient to work the trigger point by relaxing deeply and using breathing).

Treat neck, elbow, wrist, thoracic spine, and/or hand where appropriate (optional).

STEP 4 POSTERIOR – deep [see module 2] (optional)

Work with increasing depth – talking to the patient as you go (optional)

STEP 1 ANTERIOR }

STEP 2 ANTERIOR } (three times - optional)

STEP 3 ANTERIOR }

Deep and slow – especially as you approach the glenohumeral joint. Two-person technique.

STEP 4 LATERAL – deep (optional). Two-person technique (see module 2)
Work with increasing depth – talking to the patient as you go (optional).

You may want to linger here for some time, especially in the LATERAL presentations or patients with restricted abduction.

STEP 4 POSTERIOR – prone, deep [if not performed at start] (optional)

STEP 4 ANTERIOR }

STEP 5 ANTERIOR } (once only)

Biceps belly technique – (see above) for regaining APLEY: up to five minutes. Test arm range of motion carefully again. Patient dresses.

Allow a few minutes (perhaps in the reception area). Retest range of motion with patient clothed; this engenders reassurance.

Bilateral Frozen Shoulders

Typical Phase 0-I, Phase II and Phase III Bilateral Sequence – Session 8 onwards

By now the “older” frozen shoulder should have mostly resolved, and you can now spend more time and effort on the other shoulder. For the more recent case, you should follow the Phase II protocols set out for the sessions above. Again, unfortunately some patients have a severe bilateral presentation. These are clearly going to be the most difficult to manage.

For both shoulders, ask questions about changes in pain, sleep, or range of motion. Two to three minutes.

Re-examination/goniometry/special testing: three to four minutes.

You should measure the least painful shoulder first, with a sitting treatment to loosen up the neck and shoulder muscles.

You may not want to measure the more acute shoulder, as it may not benefit from being forced into the extremes even in passive motion.

Start sitting treatment – two-four minutes (don't forget to work the trigger point with the patient focusing on the breathing). Treat neck, elbow, wrist, and/or hand where appropriate (optional).

Either:

On good (or better) side:

STEP 1 ANTERIOR }

STEP 2 ANTERIOR } (three times) two to three minutes (optional)

STEP 3 ANTERIOR }

Switch to worse side then

STEP 1 ANTERIOR }

STEP 2 ANTERIOR } (three times)

STEP 3 ANTERIOR }

Work with increasing depth – talking to the patient as you go (optional).

STEP 4 POSTERIOR prone – “Experienced or Advanced practitioners” only: five to six minutes (optional). Bilaterally on least painful shoulder first

Turn patient onto their back:

STEP 4 ANTERIOR }

STEP 5 ANTERIOR } (once only): five to eight minutes. Better side first

Biceps belly technique – (see above) for regaining APLEY: up to five minutes.

Or

STEP 4 POSTERIOR – prone – good side first (once only): 15 minutes.

Some patients don't like lying on their front.

Some patients are scared to lie prone because they are not sure how to get on their front - you must use your own initiative in this scenario.

Be careful when lifting the treated arm back onto the bed as it can induce spasm.

Patient Supine:

Good shoulder

STEP 4 ANTERIOR }

STEP 5 ANTERIOR } (once only): 10-15 minutes (if you suspect the biceps tendon is very acute)

Repeat on more acute shoulder.

Retest arm range of motion, good side first.

Notes:

Part II

This section deals with modifications of the technique for other shoulder problems.

The Master's course covers the full spectrum of the NAT for the more stubborn cases and adds modifications for a range of complex shoulder complaints.

Once you have completed this NAT Master's course, you should take the reflective learning exam in order to receive your Master's certificate.

N.B: Videos will open in a new browser window.

Modifications for other Shoulder Conditions

In this section, we will explore the following:

Two-person techniques:

STEP 1 ANTERIOR

STEP 2 ANTERIOR

STEP 4 LATERAL

Modifications for:

- Biceps belly technique lateral trigger points
- Acromioclavicular joint technique treating prone
- Subscapularis tendon

The Niel-Asher Technique & RSD/CRPS

Treatment sequences for:

- Rotator cuff tendinopathy
- Supraspinatus tendinopathy/calcification glenohumeral osteoarthritis
- Triceps tendonitis
- Acromioclavicular osteoarthritis
- Subacromial/subdeltoid bursitis
- Biceps tendonitis

Notes:

Two-Person Techniques

STEP 1 ANTERIOR or STEP 4 LATERAL

In Phases II or III you may want to use a little more force.

To achieve this, you can ask a colleague to distract the arm with sustained pressure while you perform STEP 1 OR STEP 4 (LATERAL).



[Click here to play video \(video will open in new browser window\)](#)

STEP 2 ANTERIOR

In Phases II or III you may want to use a little more force.

To achieve this, you can ask a colleague to distract the arm downwards towards the floor with sustained pressure while you perform STEP 2.



[Click here to play video \(video will open in new browser window\)](#)

Other modifications:

Biceps Belly Technique

Used to increase range of motion up behind the back.



[Click here to play video \(video will open in new browser window\)](#)

The Lateral Trigger Points

The main reason for treating this area is if there is extensively reduced abduction or if the patient can only abduct in the plane of the scapula. As discussed earlier, the glenohumeral joint often glides superiorly in a frozen shoulder; this is due to the capsular shortening (shrink-wrap effect). This is often visible on x-rays of the frozen shoulder. The other factor in choosing to work laterally is if you suspect there has been an adhesive subacromial/subdeltoid bursitis. This may present on MRI or ultrasound findings.

As a rule, I tend to work on this point more as the treatment sessions progress. Over the first three to four sessions I nibble away at the point, perhaps lingering a little longer each time. If other shoulder movements are returning more quickly than abduction, you may need to work a little more vigorously into this point. Towards the final sessions I can spend up to eight minutes on this point alone! Don't forget that in most cases the glenohumeral joint is often "sucked upwards" superiorly to some degree in the frozen shoulder.

Pain-Spasm-Pain

This is a well-documented process. Pain leads to fear, and fear of movement results in the shoulder being held rigid, flexed, and adducted. The pain leads to further spasm which leads to further pain. The pain thresholds for each of us are different. You must respect the patient's wishes and assess each case on its own merits. Often, I tell such patients that the treatments may be painful, but if I go more gently it will take more sessions to improve their case; they are often more than happy with this scenario. By explaining as much as possible about the condition and treatment, you will considerably lower the patient's anxiety. It is also a good idea to talk a patient through the technique as you are treating them.

Approaching the Lateral Trigger Points - Supine

Approach the undersurface of the acromioclavicular joint – about 2cm lateral to the LHB. As you approach this area, you may feel a “clump” of shortened and knotty fascial tissue. Sustain pressure for up to four minutes on this knot in an upwards direction.

Your force should be aimed as if to distract the joint.

This is often very tender, so talk the patient through it with breathing.

Other modifications:

Acromioclavicular Joint Technique

Here, the focus of pressure is at the acromioclavicular joint. This is an important component for treating other shoulder problems.



[Click here to play video \(video will open in new browser window\)](#)

Notes:

Treating Prone

There are several types of occasions when you might consider treating prone:

With a POSTERIOR presentation

When a case seemed to be improving but then regresses

When a case plateaus

In a severely encapsulated case

At the beginning of sessions two and three in an acute Phase I case

With a POSTERIOR presentation

These are rare on their own; most often they occur in a combination, especially with the lateral presentation. In POSTERIOR cases, follow this protocol:

ANTERIOR STEPS 1-3 (3 times)

STEP 4 Lateral (if appropriate)

STEP 4 POSTERIOR (prone)

When a case seemed to be improving but then regresses

This is quite rare, but it does occur, so be prepared. Here, the patient seems to improve for pain and range of motion over three to four sessions and then they report a “flare-up.” My hypothesis is that the inflammation has “burnt itself out” at the front of the capsule/biceps tendon but has migrated to the posterior inferior capsular fold – in between two heads of the biceps.

When a case plateaus

As above, if you are struggling with a case, you may want to employ all of the techniques available to you. I would recommend the following combination:

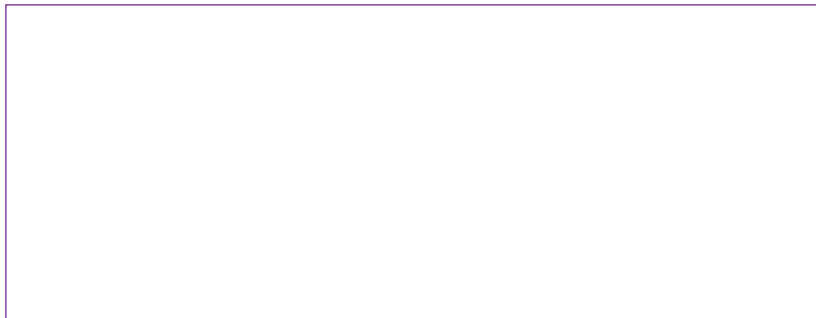
POSTERIOR (prone)

ANTERIOR STEPS 1- 3

LATERAL STEP 4

ANTERIOR STEPS 4 & 5

Notes:



Treating Prone (continued)

At the beginning of sessions 2 and 3 in an acute Phase I case

With the patient prone, work deeply into the posterior axillary fold. Find the tough and painful trigger point and hold it. You will need to work in small but increasing circles deep into the capsule as it lies between two of the triceps heads and local knotted muscles. The idea is to work on the chronic inflammation as it pools in this area. This can be an extremely painful component of the technique. Please DO NOT ATTEMPT it until you are competent with the technique.

For deepening the treatment of subscapularis/rotator cuff tendon

Standing on the opposite side to the problem shoulder, lean over the body and use your applicator (elbow or fingers) to drag and press inwards towards the body.



[Click here to play video \(video will open in new browser window\)](#)

This technique allows you to generate more force. Your pressure should be into the body, towards you. Use deep, sustained pressure until you feel a sense of ease in the trigger point. The patient may feel referred pain into the biceps tendon region.



[Click here to play video \(video will open in new browser window\)](#)

This is a modification as seen in STEP 4 POSTERIOR. This is an extremely effective point for rehabilitation in many other shoulder problems. Releasing the subscapularis tendon is an important component in:

supraspinatus tendinopathy, rotator cuff rehabilitation, biceps tendonitis, osteoarthritis of A/C joint, osteoarthritis of G/H joint

The Niel-Asher Technique & RSD/CRPS

At the beginning of sessions 2 and 3 in an acute Phase 1 case

Having treated many such cases, I am of the opinion that a portion of the intractably painful frozen shoulder is related to aberrant changes in the autonomic nervous system, specifically the sympathetic nerve chain ganglia near the base of the neck. This is a similar neurophysiology to RSD (see module 3). From an osteopathic point of view, these cases are interesting, and osteopathic high velocity thrust (HVT) techniques applied to the lower cervical spine may be of benefit.

I have also found that using the following techniques helped in some cases:

Deep myofascial work into platysma

Deep myofascial work into subclavius

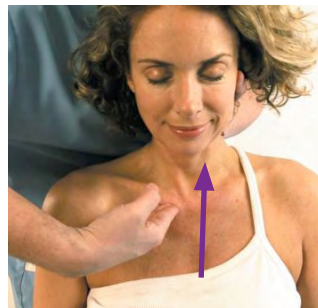
Deep myofascial and trigger point work into scalenes

Deep myofascial and trigger point work into sternocleidomastoid

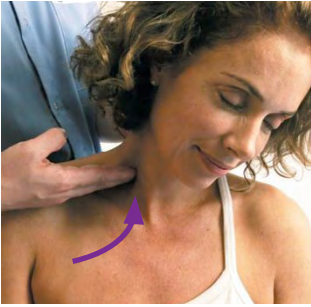
The idea is to FIND THE EXACT points in these areas that REPRODUCE the patient's symptoms. I have presented some ideas for treatment here.



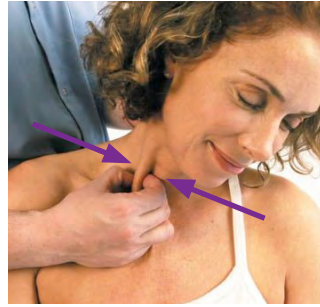
Platysma



Subclavius



Scalenes



Sternocleidomastoid

Treatment Sequences

Rotator Cuff Tendinopathy (Either A or B below):

A

Ask patient to side-lie on the non-affected side.

STEP 1 ANTERIOR }

STEP 2 ANTERIOR } (three times)

STEP 3 ANTERIOR }

Modification STEP 2 STANDING IN FRONT

Pausing here may help to generate more force on the rotator cuff tendon.

Ask patient to lie prone.

STEP 4 POSTERIOR and/or the SUBSCAPULARIS release technique

Ask the patient to lie supine.

STEP 4 LATERAL modification (moving slightly anterior to the supraspinatus tendon insertion)



STEP 1



STEP 2



STEP 3



[Click here for video](#)



STEP 4
POSTERIOR



[Click here for video](#)



STEP 4
LATERAL

Treatment Sequences

Rotator Cuff Tendinopathy

B

Ask patient to lie prone.

STEP 4 POSTERIOR

The SUBSCAPULARIS release technique (optional)

Ask patient to side-lie on the non-affected side.

STEP 1 ANTERIOR }

STEP 2 ANTERIOR } (three times)

STEP 3 ANTERIOR }

Ask the patient to lie supine.

STEP 4 LATERAL modification (moving slightly anterior to the supraspinatus tendon insertion)

STEP 5 ANTERIOR



STEP 4
POSTERIOR



[Click here for video](#)



STEP 1



STEP 2

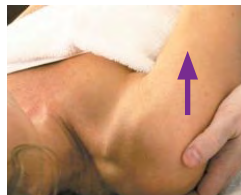


STEP 3

[Click here for video](#)



STEP 4
LATERAL



STEP 5

Treatment Sequences

Supraspinatus Tendinopathy & Calcification (Either A or B below):

A

Start with patient sitting.

This is a modification of the GENERALIZED - beginning.

Feel into the supraspinatus region, deep to the trapezius. You should feel a knotted or bunched area of tissue in the “critical zone”.

Work deep into this knot with trigger point work and friction on the painful knot.

It may help to have the patient’s hand slightly up behind their back (this may not be possible with a frozen shoulder. Work into this painful ‘lump’ until you feel it soften under pressure.

Ask patient to side-lie on the non-affected side.

STEP 1 ANTERIOR }

STEP 2 ANTERIOR } (three times)

STEP 3 ANTERIOR }

Ask patient to lie prone.

STEP 4 POSTERIOR

The SUBSCAPULARIS release technique (optional)

Ask the patient to lie supine.

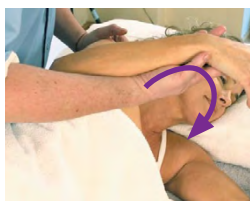
STEP 4 LATERAL modification (moving slightly anterior to the supraspinatus tendon)



STEP 1



STEP 2



STEP 3



[Click here for video](#)



STEP 4
POSTERIOR



[Click here for video](#)



STEP 4
LATERAL

Treatment Sequences

Supraspinatus Tendinopathy & Calcification

B

Ask patient to lie prone.

STEP 4 POSTERIOR

The SUBSCAPULARIS release technique (optional)

Ask patient to side-lie on the non-affected side.

STEP 1 ANTERIOR }

STEP 2 ANTERIOR } (three times)

STEP 3 ANTERIOR }

Ask the patient to lie supine.

STEP 4 LATERAL modification (moving slightly anterior to the supraspinatus tendon insertion)

STEP 5 ANTERIOR



STEP 4
POSTERIOR



STEP 1



STEP 2

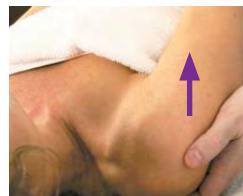


STEP 3

[Click here for video](#)



STEP 4
LATERAL



STEP 5

Treatment Sequences

Glenohumeral Osteoarthritis (Either A or B below):

A

Follow the ANTERIOR treatment protocol.

STEP 1 ANTERIOR }

STEP 2 ANTERIOR } (three times)

STEP 3 ANTERIOR }

Ask patient to lie prone.

STEP 4 POSTERIOR

The SUBSCAPULARIS release technique (optional)

Ask the patient to lie supine.

STEP 4 ANTERIOR

STEP 5 ANTERIOR



STEP 1



[Click here for video](#)



STEP 2



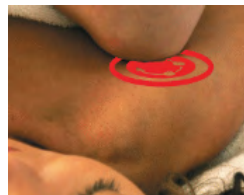
STEP 3



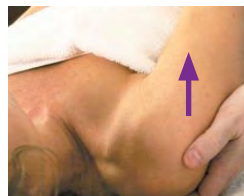
[Click here for video](#)



**STEP 4
POSTERIOR**



STEP 4



STEP 5

Treatment Sequences

Glenohumeral Osteoarthritis

B

Ask patient to lie prone.

STEP 4 POSTERIOR

The SUBSCAPULARIS release technique (optional)

Ask patient to side-lie on the non-affected side.

STEP 1 ANTERIOR }

STEP 2 ANTERIOR } (three times)

STEP 3 ANTERIOR }

Ask the patient to lie supine.

STEP 4 ANTERIOR

STEP 5 ANTERIOR



STEP 4
POSTERIOR



[Click here for video](#)



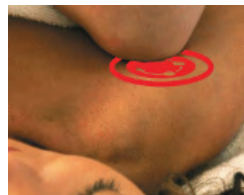
STEP 1



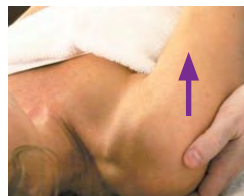
STEP 2



STEP 3



STEP 4



STEP 5

Treatment Sequences

Triceps Tendonitis

Ask patient to side-lie on the non-affected side

STEP 1 ANTERIOR }

STEP 2 ANTERIOR } (three times)

STEP 3 ANTERIOR }

Modification STEP 2 STANDING IN FRONT

Pausing here may help to generate more force on the triceps/posterior capsule.

Ask the patient to lie prone.

Work up all 3 heads of the TRICEPS.

Pause at the top of the shoulder, move around the POSTERIOR glenohumeral joint aiming towards the posterior/inferior capsule – this can be very stiff.

Pause here and deepen the pressure, localizing into the region of the capsule where it meets the long head of the triceps.

Ask the patient to lie supine.

STEP 5 ANTERIOR



STEP 1



STEP 2



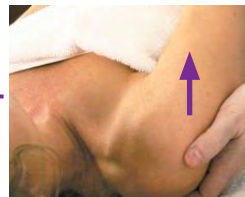
STEP 3



[Click here for video](#)



**Modification
STEP 4
STANDING
IN FRONT**



STEP 5

Treatment Sequences

Acromioclavicular Osteoarthritis

Treatment is relatively straightforward: Ask patient to lie prone (optional).

Perform SUBSCAPULARIS TENDON technique This may reproduce LHB or A/C joint pain.

Ask patient to side-lie on the non-affected side.

STEP 1 ANTERIOR }

STEP 2 ANTERIOR } (three times)

STEP 3 ANTERIOR }

Ask the patient to lie supine.

STEP 4 ANTERIOR

Pause at the top of the shoulder and move “laterally” to THE ACROMIOCLAVICULAR JOINT (inferior surface) – this can be very painful.

Pause here.

STEP 5 ANTERIOR



STEP 1



STEP 2



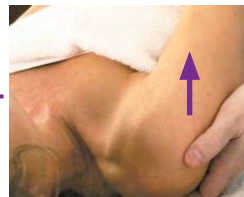
STEP 3



[Click here for video](#)



STEP 4
A/C joint
modification



STEP 5

Treatment Sequences

Subacromial Bursa

Ask patient to side-lie on the non-affected side.

STEP 1 ANTERIOR }

STEP 2 ANTERIOR } (three times)

STEP 3 ANTERIOR

STEP 4 LATERAL

2-PERSON MODIFICATION (optional)

Ask the patient to lie supine.

STEP 4 LATERAL (modified position)

Pause here for up to five minutes.

Remember you are close to the circumflex humeral artery.

STEP 4 ANTERIOR

STEP 5 ANTERIOR



STEP 1



STEP 2



STEP 3



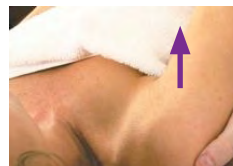
[Click here for video](#)



STEP 4
LATERAL
2 person



STEP 4



STEP 5

Treatment Sequences

Biceps Tendonitis

Ask patient to lie prone (optional).

Perform SUBSCAPULARIS TENDON technique. This may reproduce LHB pain.

Ask patient to side-lie on the non-affected side.

STEP 1 ANTERIOR }

STEP 2 ANTERIOR } (three times)

STEP 3 ANTERIOR }

Ask the patient to lie supine.

STEP 4 ANTERIOR – spending time and pausing on the long head of biceps, perform modification for BOWSTRINGING the long head biceps (optional).

Perform modification for treating in between the LONG HEAD & SHORT HEAD of the biceps (optional).

Perform modification for treating the BICEPS BELLY (optional).

STEP 5 ANTERIOR

This should reproduce LHB pain.



SUBSCAPULARIS TENDON technique



[Click here for video](#)



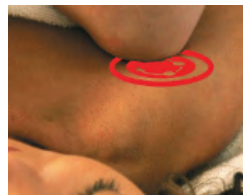
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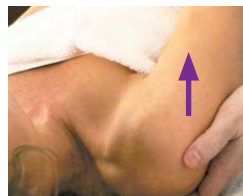
STEP 2



STEP 3



STEP 4



STEP 5

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