

# Myofascial Release (MFR) Efficacy in Alleviating Specific Symptoms in Systemic Lupus Erythematosus: Two Case Studies

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**HYPOTHESIS** – Auto-immune conditions such as Scleroderma and Systemic Lupus Erythematosus (SLE), present significant fascial – and visceral – adverse changes, which can account for much of patients' symptomatic pain and functional impairment. In turn, compression-induced vascular and lymphatic constriction can lead to ischemic pain, tissue necrosis, immune function and neural conduction impairment, with consequent motor, sensory, and autonomic dysfunction, and ensuing metabolic deterioration.

Myofascial Release (MFR) is a therapeutic modality intrinsically focused on the connective tissues/fasciae in its theoretical underpinning, clinical reasoning, & hands-on application. Its efficacy in restoring postural and functional balance as well as reversing occupational and/or health-related adaptive fascial length and 'texture' change among the 'general population' is well documented. Limited clinical evidence further suggests potential efficacy in alleviating specific aspects of Raynaud's and SLE symptoms. On this basis, MFR is hypothesised as a potentially valuable, non-invasive intervention in (a) alleviating/reducing specific symptoms of selective rheumatoid autoimmune conditions; (b) from a Psycho-Neuro-Immunology (PNI) perspective [3], modulating the underlying excessive autoimmune response(s) and enhancing immune response regulation, via the autonomic and endocrine systems, alongside raised patient psycho-emotional awareness/mental channelling and focus. Walton's [2] case study reports briefer Raynaud's attack episodes following KMI® [1] methodology-based MFR. Increased parasympathetic autonomic nervous system function and other changes after manual therapies have been recently reviewed by Moyer [4].

**METHODS** – CASE 1: A 55 year-old female with many years' SLE displayed significant fascial contracture over the R trunk-pelvic-hip region & related torsion/asymmetry, dysfunction. Constant pain required 24/7 prescription pain control, in addition to ongoing steroid & other medication. CASE 2: A 22 year-old female with SLE since age 13, with widespread fascial inelasticity & adhesion, was suffering associated pain/dysfunction, notably severe bilateral 'shin splint', L shoulder, & Low Back pain, + GI tract malfunction.

**INTERVENTION** – Patients received MFR sessions (= Rx) as follows: CASE 1: 8 Rx over 14 weeks; CASE 2: 4 Rx in 7 weeks + 3 'post Ghana' Rx in 5 weeks, given along specific KMI® myofascial meridian, neuromuscular, visceral manipulation, remedial exercise/self-awareness, and other specific modalities tailored to patient presentation/progress/targeted symptoms.

**RESULTS** – CASE 1: Symptomatic pain decreased, and Range of Motion ( RoM) and functional performance improved from Rx 1. Major gains in energy levels and key daily living autonomy, e.g. driving/walking/shopping/home chores, and greatly reduced pain medication use, by 3-4 months. CASE 2: Immediate trunk 'compression' & pain relief, and greater back & ankle RoM from Rx 1. Gradual further gains included shin tolerance of short runs, further pain relief, increased energy, patient over-coming the physical and emotional challenges of two months' voluntary 'field work' with children in a remote Ghanaian village, and incurring fewer, 'gentler' GI tract fluctuations by Rx 6 (2<sup>nd</sup> 'post Ghana' Rx).

**CONCLUSION** – These two case studies suggest broader-based future clinical research in MRT efficacy in alleviating specific effects of autoimmune illnesses affecting connective tissues, and promoting immune system integrity.

**REFERENCES** – (1) Myers T W Anatomy Trains. Edinburgh: Churchill Livingstone, 2001; (2) Walton A Efficacy of MFR in the treatment of primary Raynaud's phenomenon. JBMT 12 (3): 274-280, 2007; (3) Evans P. et al. Mind, Immunity, and Health. London: Free Association Books, 2000; (4) Moyer C.A. et al A meta-analysis of massage therapy research. Psychological Bulletin 130 (1): 3-18, 2004.