TRIGGER POINT DRY NEEDLING (TDN): INTRODUCTION AND OVERVIEW FOR PHYSICAL THERAPISTS, INCLUDING THEORY, DEMONSTRATION, AND HOW TO IMPLEMENT IT INTO YOUR PRACTICE.

WPTA SPRING CONFERENCE 2017
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OUTLINE

• Origin/Hx/Theory
• Indications /contraindication
• Training cost and days
• System barriers
• Billing
• Legal, scope of practice
• Acupuncture Differences
• Marketing
• Case studies
• Lab
WHAT IS DRY NEEDLING

- Manual Therapy Utilizing a fine filament needle to treat Trigger Points
- Needling names:
  - TDN=Trigger Point Dry Needling
  - IMS=Intramuscular Stimulation
  - IMT=Intramuscular Manual Therapy
  - FDN=Functional Dry Needling
  - DN= Dry Needling
- Needle is used to deactivate hyperirritable spots. Stimulate neuromyofascial structures, primarily used for pain.

WHAT IS DRY NEEDLING

- Solid filaform needles
- Dry needling contrasts with hollow hypodermic needles to inject substances such as saline solution, botox or corticosteroids to the same point.
- Solid needle found to be as effective, or more effective long term-(Ga et al. 2007), as injection of substances in relief of pain in muscles and connective tissue.
- Analgesia produced by needling painful spot has been called

LEARN TO NEEDLE HANDLE
RECENT HISTORY AND WHY WE ARE HERE TODAY

US states where dry needling is within the scope of physical therapy (1989-2012)

USA Dry Needling Rulings, 2002

USA Dry Needling Rulings, 2009
HISTORY OF TDN
- Dr. Janet Travell developed and popularized research and treatment of Myofascial trigger points (MTrPs)
- 1948 - Travell coined the term “Myofascial Pain Syndrome”
- 1977 Yunus – “Fibromyalgia”
- 2009 American Academy of Orthopedic Manual PT adopt TDN into scope of practice
- 2009 WI brought to scope of practice by the PTEB, therefore, WI PTs able to start practice TDN by inclusion.
MUSCLE PAIN HAS BEEN NOTED IN MEDICAL HISTORY BACK TO 1600’S.

- MTrPs British physician Balfour (1816): “Patients having large number of nodular tumours and thickening which were painful to the touch, and from which pain shot to neighbouring parts.”
- Noting the concept of referred pain.
- Balfour and Scudamore (1827) Considered this kind of muscle pain a result of inflammation in the fibrous connective tissue in muscle.

MUSCLE PAIN HISTORY

- French physician Francois Valleix (1841): “It is only with the aid of pressure ... that one discovers exactly the extent of the painful points.”
- German physician Strauss (1898) described “small, tender and apple sized nodules and painful, pencil-sized to little finger-sized palpable bands.

The Myopain seminar series is named in honor of Dr. Janet G. Travell, MD (1901-1997), a pioneer and guiding light in the study and understanding of the contribution of muscle trigger points to acute and chronic pain.

Dr. David Simons (1922-2010) became the driving force behind writing the Trigger Point Manuals, which have been translated into many foreign languages.
MUSCLE PAIN IN HISTORY

- In 1981, Travell and Simons published the first trigger point hypothesis.
- Drs. Gerwin and Dommerholt (Myofa\textsuperscript{1} pain Seminars Series) had the privilege to working and studying with both Dr. Travell and Simons. Together with Dr. Simons, Dr. Dommerholt became co-author of a literature review column on myofascial trigger points for the Journal of Musculoskeletal Pain. In 2009, Dr. Simons handed the authorship over to Dr. Dommerholt.

TDN HISTORY

Deep dry needling for treating trigger points was first introduced by Czech physician Karel Lewit in 1979.

Lewit had noticed that the success of injections into trigger points in relieving pain was apparently unconnected to the analgesic used. Essentially, the same response to a "Dry" Needle as "Injection" with the needle.

VARIATIONS IN DRY NEEDLING TECHNIQUES

Chan Gunn - intramuscular stimulation in the 1980s that moved away from using trigger points as treatment focus.
- Believed peripheral muscle spasm was not the origin of pain, but instead a tight multifidi causing spinal nerve compression, radiculopathy, and nerve damage running.
GUNN CONTINUED

• Spinal nerve damage eventually reached the associated muscle, causing spasm and transformation to a trigger point.
• Recommended a needle placed in the paraspinal muscles in addition to the distally affected muscle.

DEMO SUPRASCAPULAR NERVE ENTRAPMENT, EXAMPLE AND CASE STUDY

• 80 year old male presenting with chronic shoulder pain.
• Presented with supraspinatus and infraspinatus atrophy
• HEP and manual therapy suprascapular nerve gliding
• TDN and IMS to left suprascapular nerve pathway:

• Clinical exam: Note that supraspinatus involvement may be frequently overlooked because of the bulk of the overlying trapezius.
• Manual muscle testing may reveal relative weakness of ipsilateral shoulder abduction (a function of the supraspinatus muscle in addition to the deltoid muscle) and/or weakness of external rotation (a function of the infraspinatus muscle in addition to the teres minor muscle).
• Atrophy of the supraspinatus and/or infraspinatus muscles may be present on the physical examination, depending on the site of the nerve entrapment.
Pressure applied over the suprascapular or spinoglenoid notches may elicit pain. Tenderness may between the clavicle and the spine of the scapula or deep and posterior to the acromioclavicular joint.\(^\text{[27]}\)

- Muscle stretch reflexes are unaffected by this condition.
- More often than not, the pain (when present) is described as a deep, dull, aching discomfort.
- Activities that involve overhead motions or sport-specific skills may exacerbate symptoms. Diagnostic signs may include weakness and compromised endurance in performing overhead, sport-specific skills.

**SUPRASCAPULAR NERVE**

- **Nerve Origin:** C5, C6 roots arising as a direct branch from the upper trunk
- **Muscles Innervated:**
  - Supraspinatus
  - Infraspinatus
  - Additional pain and weakness possible in additional branches to the latissimus dorsi and teres minor muscles
VARIATIONS IN DRY NEEDLING TECHNIQUES

Peter Baldry developed **Superficial Dry Needling** in 2005

- Needle is inserted about 5–10 mm into the tissue above the trigger point.
- Baldry practiced deep dry needling until he had a patient in the early 1980s with a trigger point in his anterior scalene muscle. He only penetrated the skin for fear of puncturing a lung.
- He was so successful with this technique that he applied it throughout the body by simply puncturing the skin superficially over a trigger point without actually reaching it.

RECOMMENDED CRITERIA IN IDENTIFYING MTRPS

- Taut band palpable (if muscle is accessible)
- Exquisite spot tenderness of a nodule in the taut band
- Patient’s recognition of current pain complaint by pressure on the nodule (identifies an active trigger point)
- Painful limit to full stretch ROM
ADDITIONAL CRITERIA

- Local Twitch Response
  (involuntary contraction) in response to the needle
- Referred Pain
- Autonomic Signs and Symptoms
- MTrPs – dysfunctional neuromuscular endplate
- Contractures occurring in the muscle fibers without endplate input; i.e., independent of EMG activity

ETIOLOGY OF MTrPs

- Acute overuse
- Direct Trauma
- Persistent Muscular Contraction (emotional or physical cause), i.e., poor posture, repetitive overuse, stress
- Prolonged Immobility
- Systemic Biochemical Imbalance
- Unaccustomed eccentric contractions

ETIOLOGY OF MTrPs

- Maximal or sub maximal concentric contractions.
- Outlying associated MTrPs, i.e., primary, secondary, tertiary
- Afferent input from Joints, i.e., OA or joint injury
- Afferent input from internal organs, i.e., cancer, cardiac, gallbladder
FUNCTIONAL IMPAIRMENTS AND MTRPS

MTrP cause functional impairments in addition to pain:
- Restriction of motion
- Weakness
- Interference of Reciprocal Inhibition
- Inability to relax in between contractions

FEATURES OF MTRPS

Motor:
- Disturbed motor function
- Muscle weakness as a result of motor inhibition
- Muscle stiffness
- Restricted ROM

Sensory:
- Local Tenderness
- Referral of Pain to a distant site
- Peripheral sensitization
- Central sensitization

DEFINITIONS

Active MTrP: Symptom producing

Latent MTrP: Does Not Produce Spontaneous Pain
HOW DOES TDN HELP?

- reduces pain
- increases ROM
- normalizes activation patterns
- normalizes chemical environment

INDICATIONS / CONTRAINDICATIONS

- Inadequate practical knowledge
- Fear of Needles
- Impaired immune function
- Injuries to the skin above dry needling area
- Recent surgery (risk of infection) less than 2 weeks
- Metal allergy
- Denied consent

- Pregnancy
- Children under the age of 18 (Need parental consent and recommend be present)
- Taking anti-coagulants
- In area of joint replacement (stay outside the capsule)
- Have a bleeding disorder
- Unstable epilepsy
Myofascial Pain caused by trigger points
- Palpate, palpate, palpate

**DYSFUNCTION**
- Tendonitis/tenosynovitis/tendonosis
  - mm innervated by involved nerve
- Bursitis
  - Compression by mm shortening
- Facet irritation
  - mm’s across the joint
- Headaches
  - mm’s in neck and occiput
- Disc degeneration??
  - mm’s across involved segment
- RTC syndrome
  - Cuff mm’s
• Reverses aspects of Central Sensitization—When nociceptor input triggers a prolonged increase in the excitability and synaptic efficacy of neurons in central nociceptive pathways. Manifested as pain hypersensitivity, dynamic tactile allodynia, pressure hyperalgesia, after sensations, enhanced temporal summation, and secondary changes in brain activity that can be detected by electrophysiological or imaging techniques.

• Reduces local and referred pain

• Improves range of motion and muscle activation patterns

Alters chemical environment/mitieu of MTrP’s

• Shows 29.5% reduction in stiffness post TDN in UT

Shear Wave Elastography: Shear wave propagation showing objective quantification of muscle stiffness

Quantification of dynamic and static effects on myofascial trigger points using shear wave elastography.

Ruth M. Maker, PT, DPT, NCS, BCB-PMD, CEAS; Denis M. Heyer, PT, PhD, SCS; Mmeau, BChE, PhD, PA-C/PM
Effectiveness of Dry Needling for Upper-Quarter Myofascial Pain: A Systematic Review and Meta-analysis

- 246 articles found, 12 RCTs kept
- Based on current evidence, Dry Needling was given (Grade A evidence)
  - better than sham or controls
  - Most effective in first 4 weeks of treatment
  - More research needed

EDUCATION REQUIREMENTS

No consensus on requirements but here's a synopsis from Colorado:
- "A physical therapist must have the knowledge, skill, ability, and documented competency to perform an act that is within the physical therapist's scope of practice.
  1. Completion of a minimum of 46 hours face-to-face IMS/Dry needling course study
  2. Two years of practice as a licensed physical therapist

SEMINARS/TRAINING

- Currently, there are no specific national guidelines or requirements for a physical therapist to be able to train this technique to other PTs for CEs and ability to implement into practice.
- APTA does provide the following information that PTs should take into account when considering ANY continuing education course:
  [http://www.apta.org/CareerManagement/ValuingContinuingEducationPrograms](http://www.apta.org/CareerManagement/ValuingContinuingEducationPrograms)
• APTA does not, at this time, have any guidelines specifically for PTs who want to be able to teach dry needling to other PTs. However, if a dry needling CE course was to be sponsored by APTA, then such an APTA-sponsored course would need to meet our CE standards (APTA is accredited by IACET as an approved continuing education provider, as such we must meet a number of IACET standards when it comes to offering CE).

• In addition, a majority of state require continuing education courses be reviewed and approve before they can count toward a PTs licensure renewal. So if PT wants to be able to utilize a dry needling CE course toward their licensure renewal requirement, such a CE course would need to have been approved by the state.

• Given that dry needling is an invasive technique that is not considered entry-level, it would be prudent for anyone who chooses to teach such a course to be properly trained with adequate clinical experience performing the technique on patients. It would be inappropriate for an PT to be a CE instructor for dry needling, or for any intervention for that matter, with little to no actual clinical experience performing it.

Justin Elliott
Director, State Government Affairs
American Physical Therapy Association

EDUCATION PERSPECTIVE
**TRAINING COSTS**

- Functional Dry Needling 3day course:
  - FDN-Level 1: $1250
  - FDN-Level 2: $1250
  - Advanced FDN-Level 3 $1000
  - Functional Therapeutics: $1100
- Integrates SFMA & FMS with FDN

This Foundational course completes the Course of Study to become a Functional Dry Needling® practitioner. Prerequisites include Functional Dry Needling Level 1 plus a completed log demonstrating dry needling of 200 treatment sessions. If practitioners choose our intermediate level Functional Therapeutics, then only 100 dry needling sessions are required. Learn more advanced muscles on FDN Level 2, including those of the thoracic region, abdomen, head and neck.

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**EDUCATION PERSPECTIVE**

**JENNIFER JESCHKE, DPT**

- DPT Northwestern University 2003
  Chicago, IL

- Private Practice 2004 to Present
  Lake Mills, WI

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[KinetaCore Marketing Video You-Tube](http://www.youtube.com/watch?v=-1bst-eDCjwg&authuser=0)
Myopain Seminars – Milwaukee WI 2011-2012
~110 hours of course time
- Drs. Robert Gerwin, MD and Jan Dommerholt, PT, DPT studied and worked with Drs. Travell and Simons
- Methodology influenced by the work of:
  - Dr. Peter Baldry (UK)
  - Mr. Christian Grobli and Dr. Beat Dejung (Switzerland)
  - Dr. Andrew Fischer (US)
  - Dr. Chan Gunn (Canada)
  - Dr. Vladimir Janda and Dr. Karol Lewit (Czech Republic)
  - Dr. Leon Chaitow (Greece)
  - Dr. Siegfried Mense (Germany)

EDUCATION & COST

Four 3-day courses (approximately 1-2 months to practice between each course)
- 1 - The DN-1 Foundations - brief introduction to the history of dry needling, trigger points and myofascial pain, the OSHA Blood Borne Pathogen Standards within the context of dry needling, and an introduction to relevant pain sciences.
- 2 - Head, Neck, Shoulder
- 3 - Hips, Back, Pelvis
- 4 - Extremities
- One 5-day review course and certification exam
- Cost was $750 per course (4), $1500 for review course and exam = $4500 over 6 months series

 Changed In 2013 to 4 courses, then again in 2014 to 3 courses:
- Myopain Seminars has revised and updated the Dry Needling course program. The program consists of a 2-level Foundation course and a 1-level Advanced course. All courses include online lectures that students will complete in the comfort of their own home or office.

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<tr>
<th>Now Description</th>
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<tr>
<td>DN-1 and DN-2</td>
<td>US $995 each</td>
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<td>DN-3</td>
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EVIDENCE IN MOTION, LLC

- Bought kineticore

SUE FALSONE'S SYSTEMIC DRY NEEDLING IS A CONTEMPORARY DRY NEEDLING APPROACH CREATED BY DR. YUN-TAO MA, BASED ON THE WORKS OF DR. JANET TRAVELL, DR. CHAN GUNN, NEUROPHYSIOLOGY AND NEUROANATOMY, CLINICAL EXPERIENCE, AND EVIDENCE BASED RESEARCH IN NEUROSCIENCE.

1 3-DAY WEEKEND COURSE
$1295.00

IDN
Dr. Ma's Integrative Dry Needling for Physical Therapists

HTTP://WWW.SPINALMANIPULATION.ORG/

- DN-1: Dry Needling for Craniofacial, Cervicothoracic & Upper Extremity Conditions: an Evidence-Based Approach (Part 1 of the Certification in Dry Needling)
- DN-2: Dry Needling for Lumbopelvic & Lower Extremity Conditions: an Evidence-Based Approach (Part 2 of the Certification in Dry Needling)
- https://www.spinalmanipulation.org/seminar.php?id=11

No prerequisites are needed for this three-day 27-hour course in dry needling; however, registrants must be a licensed physical therapist, osteopath, medical doctor, naturopathic doctor or acupuncturist in their respective state or country. Certification in Dry Needling™ (Cert. DN™) will be awarded upon successful completion (i.e. written and practical examination) of both the DN-1 & DN-2 courses, giving 54 hours of hands-on dry needling education in total.
Institute of Advanced Musculoskeletal Treatments

LEVEL 1 - This course is designed to teach introductory level techniques for trigger point dry needling throughout the entire body. 2 days (16 hours) $900

LEVEL 2 - This course is a continuation of the Trigger Point Dry Needling Level 1 course with the addition of more challenging techniques. The course covers techniques surrounding the thoracic region, face, head and neck as well as the deep muscles in the lower extremities. 3 days (27 hours) $1200

SYSTEM BARRIERS (LAKE DELTON 2008)

- Approval process went all the way to CEO
- Took over a month to get rolling

UW Dry Needling Provider Requirements:

- 2 years out of school
- Certified in TDN
- Licensed to practice PT
- Competency Checks-meeting bi-annually with other providers
- Written & Verbal Consent
- In depth documentation
RESOURCE FOR TDN LEGISLATIVE AND LEGAL ISSUES


WISCONSIN TDN LAWSUIT

- Acupuncture Center, Inc. d/b/a Midwest College of Oriental Medicine and Wisconsin Society of Certified Acupuncturists, Inc. versus PTEB, Wisconsin Department of Safety and Professional Services, and Wisconsin Joint Committee for Review of Administrative Rules

  - Case was dropped in 2014

WISCONSIN TDN LAWSUIT

- Recent lawsuit filed against the PTEB etc to challenge an interpretation of the PTEB that TDN was within the scope of PT.
- Also challenged the process that was used to disseminate that info on the PTEB website.
- Recently learned that the lawsuit was dismissed! (2/4/14)
OTHER CHALLENGES

• National Center for Acupuncture Safety and Integrity
  • Attempted to restrict the sale of acupuncture needles to anyone other than a licensed acupuncturist under the FDA Act 21
  • APTA legal analysis concluded the NCASI letter was without merit
  • FDA down classified acupuncture needles to class II medical devices, stating they are to be used by qualified practitioners, as determined by state guidelines.

ACUPUNCTURISTS STRATEGIES

• Currently monitoring other strategies that may include:
  • Direct legislation against PT’s
  • Indirect legislation (putting up a fence)
  • Media campaign?

• The FOSB stated that Intramuscular Manual Therapy (previously known as Trigger Point Dry Needling) is in the Scope of Practice of US trained physical therapists.
  • PTs using intramuscular manual therapy:
    • do not and cannot claim to practice acupuncture
    • do not use acupuncture traditional Chinese medicine theories, meridian acupoints and terminology, • do not use acupuncture diagnosis like tongue and pulse
BILLING (OPINIONS/SUGGESTIONS?)

MUCH DEBATE:
• Official position (from the APTA Coding and Reimbursement Course) is that it is billed as an unlisted modality (97039) or unlisted procedure (97139). Then it depends on the insurer as to whether they will pay. There is no specific code for dry needling.
• To bill it any other way is technically considered fraudulent although it is common practice to capture the time of the dry needling in with other codes, especially manual therapy, and often taught that way.

BILLING

• NOT necessarily represent the majority opinion; just citing one very important official position
• Dry Needling is not anywhere near by itself a treatment, just like other assisted manual therapy techniques = TOOL
• Many PT perspectives: Dry Needling, like Graston, is instrument assisted manual therapy. Manual therapy (97140)
BILLING/STATE PRACTICE ACT

#1 - make sure that your state practice act allows it. Some PT practice acts do not allow PT use of dry needling.

#2 - check with individual insurances on their coverage determination. Some still may require it billed under the unlisted procedure. While a number of manual therapy organizations and international PT Associations have positions that it is manual therapy (which many agree with), not always the official position on dry needling’s designation so care must be taken before you do it and before you bill it to know if it is allowed and how to bill it. Simply calling it

STATE PRACTICE ACTS

- Dry needling is practiced by PTs in many countries, including South Africa, Bangladesh, the Netherlands, Spain, Switzerland, Canada, Chile, Ireland, the United Kingdom, Australia and New Zealand.

- United States: At this point in time, State Board of the following States consider dry needling to be within the scope of PT practice: see 2017 map.

PRACTICE ACT

- Hawaii is the only state where the PT practice act includes language prohibiting PTs from penetrating the skin. Most other states have issued interpretations, which are not necessary reflected in the practice act.

- State Boards of several states, including Minnesota, Iowa do not have a formal opinion on the issue, but have no direct objection to DN by PTs.

- Chiropractors are legally allowed to practice dry needling in many States including Alabama, Colorado, Connecticut, Delaware, Florida, Illinois, Maryland, New Hampshire, New Mexico, North Carolina, Rhode Island, South Carolina, Texas, Utah, Virginia, and West Virginia.
BILLING

Some State Boards are not allowed to issue interpretations of the PT Statutes, including Pennsylvania, Arizona, and Delaware.

- In August 2010, the PT Board of PA did issue a statement against dry needling in spite of having no authority to issue such a statement. The PA PTA challenged the PA PT Board and requested from the PT Board to retract the advisory position on dry needling.

- Idaho did not approve dry needling in August 2009, based upon the fact that trigger point dry needling is an invasive procedure, and invasive procedures are not within the physical therapy scope of practice. Of interest is that nerve conduction studies, electromyography, wound debridement, etc. are invasive procedures that are within the scope of PT practice in Idaho.

PRACTICE ACT

2014 "The Wisconsin PT Board along with two other state agencies was currently being sued by acupuncture organizations demanding that the PT Board issues a statement that DN is not within the scope of PT Practice.

...Business as usual for PTs...nothing prevents PTs that are adequately trained to continue to perform dry needling. It's a good idea for people to be aware of what is happening nationally and in WI, which suggests a PT may be under more scrutiny/risk for being reported to the state licensing agency (DSPS). The WI Society of Acupuncturists believe that PTs should not be doing this, so I would not be surprised if some PTs get reported. The PTEB will investigate any complaints on a case by case basis so anyone doing this intervention (or anything else for that matter) need to feel confident they can defend what they are doing based on education, skills, training, competency, etc.

- Kip Schick, PT
WPTA president

BILLING/PRACTICE ACTS?

- With respect to the APTA position, the initial plan was to form a workgroup to evaluate billing issues immediately after the APTA would issue its educational resource papers, which were published in 2012 and 2013. At this point in time, there is little interest to initiate this workgroup as the APTA is proposing a different payment system.

"It is my opinion that dry needling is indeed an instrument-assisted manual therapy and that the 97140 code is the most appropriate code. Unfortunately, there is no consensus and the arguments continue. - Jan Dommerholt

Myopain Seminars/Bethesda Physiociare
BILLING

- https://www.webpt.com/blog/post/billing-for-dry-needling

Can’t We All Just Get Along?

TDN VS. ACUPUNCTURE

- Working with Acupuncturists toward patient
**ACUPUNCTURE IS NOT TDN**

**Acupuncture**
- Based on Eastern Dx
- More than needling
- Chinese Medicine
  - Targets Yin and Yang
    - Imbalance of internal forces
  - Targets Systemic issues
    - 3 years of study

**TDN**
- Treats neurovascular system
- Depends on Orthopedic Exam
- Targets Local tissue responses
  - Overuse vs injury
  - Myofascial pain
  - Adjunct to medical degree
  - 50hrs post graduate
- 200-400 interventions
- Needling is like acupuncture

**MARKETING ITEMS**
- Ex. Kineticore video
- FAQ handouts
- JOSPT handout

https://www.youtube.com/watch?v=1bst-eDCiwg

**LUMBAR HNP CASE STUDY**
- 27 year old female
- Work injury lifting twisting.
- Full leg numbness, tingling and shooting pain upon weight bearing left LE.
- MRI findings: L5-S1: There is a moderate to large left paracentral disc protrusion/extrusion, resulting in narrowing of the left lateral recess, and mass effect on the traversing left S1 nerve root. There is no significant central stenosis, and the neural foramina remain relatively patent.
- Presenting Oswestry LBP 66%
LUMBAR HNP CASE CONT.

- Treatment B L4-S1 multifidi, longissimus, Left lateral gastrocnemius.
- Numbness resolved 90% in 1 treatment TDN and IMS
- 4 TDN treatments total over 2 months
- Reported 0% Oswestry on discharge
- HEP TrA control, functional posture and core stabilization progression. High level work requiring combat tactics.
- At discharge reported only mild residual cramping on exertion in lateral gastrocnemius.
- Spinal posture on MRI noted significantly flat thoraco lumbar spine with hyperlordosis L5, anterior tipped sacrum.

PLANTAR FLEXION WEAKNESS
- IPSILATERAL, UNABLE TOE WALK.
- ABSENT ACHILLES REFLEX S1.

CASE STUDY – FROZEN SHOULDER
- 53 y/o Female Bilateral Severe Frozen shoulders >10 month since onset
- Reporting 10/10 pain
- Received 2 cortizone injections by Ortho surgeon with little relief. Tramedol, Naproxen, and Valium for pain.
- Was seen by PT for several months, then referred to me for TDN by PT
- ROM 0 degrees ER, 60 degrees flexion
- MMT 3/5 Bilateral shoulders
- SPADI scores initial: Pain 90%, disability 68%

See also JOSPT Feb 2014 Trigger Point Dry Needling as an Adjunct Treatment for a patient with Adhesive Capsulitis 83 180.
MUSCLES TREATED

- 1st visit – Right shoulder worse, so treated TDN
  Right Pectoralis Major, Subscapularis mm. HEP lie supine with attempting forearm supination/shld ER
  60 minutes total per day (low load/long hold)
- 2nd visit – report pain improved from 10/10 to 3/10. TDN Pec Major, minor, lateral/deltoid, subscapularis, infraspinatus.

FROZEN SHOULDER

- Continued to progress self stretching
- As improved pain and ROM, was able to perform self stretching, whereas was not able at initial.
- Visit #5 (1 month PT/TDN) ROM flexion 90 degrees, ER 10 degrees. SPADI pain score 0% left, 81% Right (pain now focal to Right Upper trapezius), disability score 69%. Now using TENS unit effectively for pain.
- 6 week visit #8 pt. fell, pain increased to 1-2/10. SPADI pain score 6%, disability score 45%. ROM minimal change.

3 months visit #11: Flexion 90, ER 13deg, MMT 4-5.

INTRAMUSCULAR STIMULATION


- Kineticore perspective – motor reeducation
- Gunn Concept - neuromodulation
- Using for radiating pain and weakness
- Post Laminectomy Case Studies
- Gluteus Medius Tear or weakness
CLINICAL PEARLS

• Needling is rarely a stand alone treatment
• Effective at decreasing peripheral pain
• MTrP’s can be eliminated with other manual techniques (but TDN is faster)
• MTrP’s can affect joint function, movement patterns, injury risks, further muscle overload

PEARLS CONTINUED

• Kinesiotaping post treatment to assist with NMR and post treatment soreness.

HTTP://WWW.APTA.ORG/PTINMOTION/NEWS/2016/6/7/CHOOSEPTCAMPAIGNLAUNCH/
DEMONSTRATION

- Palpation, palpation, palpation
- Precautions
- Needle type
- Needle insertion
- Treatment
- Aftercare
- Plan

REFERENCES

- Trigger Point Dry Needling: An Evidence and Clinical-Based Approach
- Myofascial Trigger Points: Pathophysiology and Evidence-Informed Diagnosis and Management


• OBCE & Oregon State Attorney General Motion Requesting Reconsideration of Administrative Stay, September 27, 2011 [dead link]

• Order Denying Motion for Reconsideration, Court of Appeals, State of Oregon, No. A148924, November 10, 2011


• Rainey CE. “The use of trigger point dry needling and intramuscular electrical stimulation for a subject with chronic...”