OMT for Healthy Aging

Menopause and Beyond

Osteopathic physicians should take advantage of opportunities to incorporate osteopathic manipulative treatment in health management plans for menopausal women.

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Osteopathic physicians can positively impact the health of their menopausal patients. In addition to addressing patient concerns about treatment options for vasomotor symptoms, changing body shape and function, they can evaluate the musculoskeletal system for somatic dysfunction to address structural factors influenced by aging.

Osteopathic manipulative treatment may increase range of joint motion, influence circulation, improve posture and locomotion, and reduce the pain of arthritis.

Adjunctive therapy such as diet and exercise can also be incorporated into the care plan to encourage a healthy aging process. Following are some suggestions for incorporating manipulative treatment in women’s healthcare to provide comprehensive health management of active women.

Starting from the ground up, record the patient’s height at least annually as a clinical indicator of postural changes from osteoporosis. If she appears to be shrinking, anterior-posterior spinal curves should be evaluated.

Any lateral curves or increase of scoliosis should also be noted. Exaggerated thoracic kyphosis or lumbar lordosis may influence the pelvic bowl to tilt forward. This pelvic tilt may aggravate urinary or bowel incontinence as the pelvic floor continues to weaken from structural distress.

Somatic dysfunction of the sacrum and pelvis should be identified. Muscle-energy, balanced ligamentous tension, counterstrain, or myofascial treatment techniques could be utilized. During a pelvic exam, discuss and evaluate pelvic muscle tone.

Issues of dyspareunia, bladder or bowel function may have a biomechanical basis that is amenable to musculoskeletal treatment. Selection of treatment modality would be dependent on whether the dysfunction is in soft tissues, ligaments, circulatory system, or bones and joints.

Some patients may have low back pain from lumbar disc disease or an unlevel sacral base as a result of osteoarthritis or injury. These patients may not be able to stand erectly. They may also experience pain with walking, standing or sitting.
Muscle energy or indirect techniques to the lumbosacral spine could be performed while the patient is sitting or standing. Patient positioning for treatment may depend upon placing her in a comfortable position or using her weight, respiratory effort and posture as adjunctive measures. Such a patient may have a large body habitus that challenges the physician to perform a treatment procedure in a recumbent position. Or the patient may not be able to breathe lying supine.

After somatic dysfunctions of the pelvis have been identified and addressed, other pain or gait problems may be reported by the patient. While examining the lower extremities for cyanosis, edema, and varicosities, the physician can observe gait.

Painful gait may be result of plantar fasciitis, flat feet, or somatic dysfunction as evidenced by identification of counterstrain tender points on feet, ankles, and knees.

Posterior fibular head dysfunction as well as inflammatory arthritis may contribute to genu valgus. Addressing gravitational strains and muscle imbalances before referring the patient for orthotic devices might relieve pain and save money from purchasing shoes that may be neither helpful nor comfortable.

Evaluation of the thoracic spine and rib cage may reveal viscerosomatic dysfunction. Compression fractures are common around the level of the 8th or 9th thoracic segments. Digestive complaints such as reflux, hiatal hernia, or eructation may correlate with joint restriction in the mid to lower thoracic spine.

Inability to take deep breaths may be due to restricted motion of the thorax and clavicles. This affects posture and upper back pain. Compromised motion of upper ribs and thoracic spine may cause edema in the neck and upper extremities.

Menopausal women often have shoulder pain that may be due to arthritis that was aggravated by lifting such heavy items as groceries or grandchildren. Gentle range of motion techniques or myofascial stretching may retard shoulder impingement. Trigger points may uncover fibromyalgia or areas of referred pain of which the cause of upper extremity pain is not limited to the extremity itself.

Complaints suggesting carpal tunnel syndrome may be the result of somatic dysfunction of interosseous membrane of the forearm or of the cervical spine. Structural evaluation of the cervical spine and notation of range of motion help assess the patient’s ability to turn her head and neck in order to perform such simple tasks as backing her auto out of the garage or parking space. Severe arthritis with bone spurring or limited range of motion should preclude performance of any treatment technique that may place the cervical spine in a position of hyper-extension or hyper-rotation to avoid vertebral artery injury or stroke.

Headaches due to muscle contraction with vascular congestion or increased cervical lordosis may be relieved with treatment of the occipital-atlantal junction just beneath the skull. Increased range of motion of this area may also be the result of muscle relaxation. While the patient’s head and neck are being treated, she may be physically relaxed enough to discuss psychological or emotional stressors which may also require her physician’s assistance.

Opportunities to incorporate osteopathic manipulative treatment in health management plans for menopausal women who desire to age gracefully have been discussed. Osteopathic physicians can update their skills and techniques by attending courses offered by state associations, osteopathic college post-graduate programming, college of osteopathic family practice, or the American Academy of Osteopathy. Osteopathic physicians who focus their practice on neuromusculoskeletal medicine and manipulative medicine can provide more in-depth evaluation and treatment of structural problems referred to them by colleagues or other patients.

Reference

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