Facilitated Positional Release (FPR)

Objectives:
To gain an understanding of the principles of FPR.
To gain an understanding of ways to apply FPR to clinical cases.

Background
Definitions from the Glossary of Osteopathic Terminology:
1. Facilitated Positional Release (FPR): A system of indirect myofascial release treatment. The component region of the body is placed into a neutral position, diminishing tissue and joint tension in all planes, and an activating force (compression or torsion) is added.
2. Functional Technique: An indirect treatment approach that involves finding the dynamic balance point of one of the following: applying an indirect guiding force, holding the position or adding compression to exaggerate position and allow for spontaneous readjustment. The osteopathic practitioner guides the manipulative procedure while the dysfunctional area is being palpated in order to obtain a continuous feedback of the physiologic response to induced motion. The osteopathic practitioner guides the dysfunction part so as to create a decreasing sense of tissue resistance (increased compliance).

Facilitated Positional Release (FPR)
Indications
1. Acute or chronic somatic dysfunctions
2. As primary treatment or in conjunction with other approaches
3. Muscle spasticity

Relative Contraindications
1. Patient who cannot voluntarily relax
2. Severely ill patient
3. Severe osteoporosis
Absolute Contraindications
1. Absence of somatic dysfunction
2. Lack of patient consent and/or cooperation

Cervical Soft Tissue or segmental FPR\textsuperscript{1,2}

1. The patient is supine on the table with their head beyond the end of the table on a pillow in the practitioner’s lap or the head on the table to the patient’s comfort.
2. Cup the patient’s neck in the palm of your hand with the pad of the index or other finger acting as both the monitoring finger and fulcrum on the ipsilateral tense tissue to be treated. Your thumb rests on the other side of the neck.
3. Use your non-monitoring hand on the top of the patient’s head to flatten the cervical lordosis by slightly forward bending the neck to the position.
4. Use the same hand to apply a compressive facilitating force to the neck through the patient’s head until felt at the monitoring finger.
5. Maintain the compressive force and introduce mild extension of the neck to the level of the monitoring finger. (If tissues being treated are anterior rather than posterior, introduce flexion rather than extension.) This should cause a palpable softening of the tissue being treated.
6. Add side-bending and rotation (usually toward the side of the tense tissues) to the point that the tissues continue to soften into a position of ease.
7. Hold in this position for 3-5 seconds or until the tissue releases completely and then return the neck slowly to a neutral position.
8. Reevaluate the tissue being treated.

Anterior Ribcage and Costochondral Dysfunction\textsuperscript{1,2}

1. Patient position is seated with the practitioner standing ipsilateral to the dysfunction.
2. Palpate the dysfunctional rib or costochondral junction.
3. The patient is instructed to sit up straight until the thoracic kyphosis straightens to the dysfunction.
4. While palpating the dysfunction, take the opposite hand over the superior aspect for the patient’s shoulder at the acromion process.
5. The physician applies compression at the cervicothoracic junction and shoulder, directly toward the floor. (Do not allow forward
bending.)

6. Maintaining the compressive force, the practitioner sidebends toward and rotates toward the dysfunction.

7. The position is held for 3-5 seconds or until the tissue is released and then released returning the patient to neutral.

8. Reevaluate the tissue being treated.

**First Rib Somatic Dysfunction/First Rib Soft Tissue FPR**

Example: 1st rib elevated on left

1. Patient is in the supine position with the practitioner seated on the side of the dysfunction.

2. Place the monitoring finger of your right hand over the posterior portion of the left first rib. The hand placement may be modified to treat soft tissue only, or at the costovertebral junction to obtain a first rib articular release. The finger should contact the tensest tissue overlying the superior posterior part of the rib.

3. With your left hand, grasp the patient’s left elbow, flex the upper arm to approximately 90 degrees, and abduct the upper arm to the position in which the tissues soften.

4. Fine tune with internal rotation, the tissues will soften maximally.

5. Create a compressive force through the left elbow downward, directed toward the monitoring finger.

6. Hold this position for 3-5 seconds or until the tissue is released.

7. Return to neutral position.

8. Reevaluate the motion of the first rib.

**Posterior Rib Dysfunction**

**Seated**

1. Patient is seated at the edge of the table or on a stool with the practitioner standing behind the patient on the side of the dysfunction.

2. The practitioner monitors the somatic dysfunction with the hand farthest from the patient.

3. The patient is asked to sit up straight and push his chest forward to flatten the spine to the point of the dysfunction.

4. The practitioner’s forearm is placed across the back at the level of T1. With his arm he compresses the thoracic region
downward and side bends the region to the side of the dysfunction. With his elbow he adds a rotary force drawing the patient’s shoulder posterior localizing to the side of the somatic dysfunction until the position of ease is found. 

5. This position is held for 3 to 5 seconds or until the tissue is released. 
6. Return to neutral position. 
7. Reevaluate the motion of the rib.

Prone

1. Patient is prone on the table with the practitioner standing ipsilateral to the dysfunction. 
2. He places the index finger of his cephalad hand on the costotransverse articulation to monitor motion. 
3. With the hand on the ipsilateral shoulder he induces a compressive force toward the patient’s feet. 
4. A rotational torsion force may be added until the tissue texture softens and the position of ease is found. 
5. The position is held for 3 to 5 seconds or until the tissue is released. 
6. The shoulder is returned to neutral position. 
7. Reevaluate the motion of the rib.

Superficial Muscle Hypertonicity FPR of the Thoracic Region

1. Patient is seated. Practitioner stands behind and to the side of the involved muscle (tight part of the muscle belly). 
2. The practitioner places an index finger on the site of the dysfunction. 
3. The practitioner’s opposite arm is placed on the patient’s left shoulder with the elbow at the lateral aspect to allow direction and control of the patient’s motion. The practitioner’s forearm rests behind the patient’s neck. 
4. The patient is instructed to sit up straight until the thoracic kyphosis flattens slightly. 
5. If necessary the patient is told to push his chest out until backward bending is created up to the monitoring finger, for further flattening of the thoracic spine. The practitioner applies compression with his forearm near the patient’s neck. The vector of force is aimed straight down the parallel spine. 
6. Maintaining the backward bending and compression, the practitioner creates side-bending toward and rotate toward the dysfunction. 
7. This position is held for 3 to 5 seconds or until the tissue is released and then brought back to neutral. 
8. Reevaluate the muscle.
Thoracic Spine and Ribcage FPR\(^1\), \(^2\)

Seated

1. Patient is seated on the edge of the table with the practitioner behind and to the left of the patient.
2. Ask the patient to sit up to flatten the spine to the dysfunction and push the chest forward. This will straighten the thoracic kyphosis.
3. Monitor the transverse process with your index or other finger.
4. Place your opposite arm across the back at the level of T1 with your compression hand over the contralateral shoulder (to the dysfunction).
5. Add a compressive force though the center of the spine downward (toward the table), causing left side-bending down toward the side and at the level of the dysfunction.
6. Add flexion to the level of dysfunction by pulling the patient forward on the patient’s shoulders while maintaining the side-bending.
7. Rotate the thoracic spine toward the dysfunction by pulling the patient’s shoulder forward to find the position of ease.
8. Hold this position for 3-5 seconds or until the tissue is released and then slowly return the patient to a neutral position.
9. Reevaluate motion of the thoracic spine.

Prone

1. Patient is prone with pillows beneath the abdomen at the level of the dysfunction and head with the patient’s arms at his or her sides. The practitioner is standing at the right side of the patient.
2. Palpate the posterior transverse process with the fingers of your right hand.
3. With your other hand, grasp the patient’s anterior clavicle and pull. The patient’s entire shoulder should be held with your fingers on the upper and outer surfaces.
4. Pull the patient’s shoulder medially toward the spine. This flattens the spine in the anteroposterior plane) then toward the patient’s feet (this compressive force creates left side-bending)
5. Stand up straighter, pulling the patient’s shoulder posterior and creating left rotation down through the level of dysfunction into the position of ease.
6. Hold this position for 3 to 5 seconds or until the tissue is released then slowly return to the neutral position.
7. Reevaluate motion of the thoracic spine.

*Note: If the diagnosis is flexion rather than extension, FPR is more easily accomplished in the seated position.*

**Deep Muscle Hypertonicity FPR of the Lumbar Region**

1. The patient is placed in the lateral recumbent position.
2. The practitioner monitors the area of L1-L2 with the index and middle finger to look for a position of ease.
3. The practitioner flexes the hip and knee until L1-L2 feel like they have come into a position of ease.
4. The practitioner applies a compressive force down the long axis of the femur.
5. This position is held for 3 to 5 seconds or until the tissues are released.
6. Return the patient to a neutral position.
7. Reevaluate the lumbar muscles.

**Discogenic Pain Syndrome and Superficial Muscular Hypertonicity FPR**

1. Patient is prone and close to the left edge of the table with a sufficient number of pillows beneath the abdomen to cause flattening of the lumbar lordosis. The practitioner sits on a rolling stool on the ipsilateral side of the table (thighs parallel to the table) at the level of the patient’s pelvis, facing the patient’s head.
2. Use a finger to monitor the area of documented or suspected disc pathology for a position of ease.
3. With your opposite hand, flex and abduct the patient’s left hip and knee.
4. Localize motion to the involved segment by moving the patient’s leg in a cephalad direction. It is easiest to do this by rolling the stool closer to the head of the table. While rolling forward, the physician drops the opposite knee (away from the patient) to allow for greater abduction as needed.
5. Create a traction force at the popliteal fossa that can be modified (as you further raise and move your knee laterally) until you palpate motion at your monitoring finger. The practitioner’s knee is now at the medial surface of the popliteal fossa while the lateral surface of the knee acts as a fulcrum for the rest of the technique.
6. Push the patient’s lower leg toward the floor until motion is palpated at the monitoring finger. Note a slight amount of initial tension at the monitored location.
7. Maintain this position until a release is noted, generally in 3 to 5 seconds, and then slowly return to a neutral position. The patient generally experiences some relief of his or her radicular symptoms with this treatment.
8. Release traction and replace the leg back onto the table; do not allow the patient to do any of the work.
9. Reevaluate the lumbar region.

**Lumbar FPR**\(^1,2\)

**Extended (Prone) – Example: L3 E S\(_L\)R\(_L\)**

1. Patient is in the prone position close to the left edge of the table with a sufficient number of pillows beneath the abdomen to cause flattening if the lumbar lordosis. The practitioner stands at the left side facing the head of the table.
2. Monitor the posterior transverse process (left) with a finger of the right hand.
3. Place a small pillow between the patient’s left thigh and the table. This will provide a fulcrum for the treatment while protecting the thigh from the pressure of the table’s edge.
4. Use your left hand to abduct the right leg, creating left lumbar side bending, and stand between the table and the patient’s abducted leg.
5. Grasp the patient’s left lower leg or ankle and internally rotate the leg until you feel motion at the monitoring finger (this creates relative rotation of the trunk to the left).
6. Move the patient’s abducted leg toward the floor (hip flexion) until you palpate motion and a position of ease at the monitoring finger. With the thigh pillow acting as a fulcrum, lift the pelvis from the table and introduce lumbar extension.
7. Hold this position until there is sudden release of the somatic dysfunction (usually about 3-5 seconds), then slowly return the patient to a neutral position.
8. Reevaluate lumbar motion.

**Flexed (Prone)**

1. Patient is prone and lying close to the edge of the table with a sufficient number of pillows beneath the abdomen to cause flattening of the lumbar lordosis. Practitioner is sitting on a rolling stool (thighs parallel to the table) on the side of the dysfunction at the level of the patient’s pelvis, facing the patient’s head.
2. Monitor the posterior transverse process with a finger in order to assess the position of ease.
3. Flex the patient’s leg at the knee and hip, with the lower
leg coming to rest between your knees to create a relative amount of flexion at the spine to the point where motion is felt of the spine at the monitoring finger.

4. Use your hand to grasp the patient’s knee and adduct it toward and under the table until you feel motion at the monitoring finger. Hold and support the knee during the rest of the technique. Rotate your body clockwise (This induces left rotation, because internal rotation of the leg causes pelvic rotation to the contralateral side, and relative lumbar rotation toward the posterior transverse process.) Add compression through the patient’s knee.

5. Hold this position until there is a sudden release of the somatic dysfunction (usually about 3-5 seconds) then slowly return the patient to a neutral position.

6. Reevaluate lumbar motion.

**Pubic Symphysis Restriction FPR**

1. Patient is supine with the practitioner standing on either side of the table facing the patient’s head.

2. If the practitioner is standing on the right side of the patient, the physician places one finger of his right hand at the pubic symphysis to monitor motion and position of ease and, using his left hand, bends the patient’s right hip and knee at 90 degrees to the table.

3. The practitioner leans on the patient’s knee, causing a force downward toward the table with compression of the hip joint.

4. The practitioner pushed the right knee and hip joint into adduction, until motion is felt at the monitoring finger.

5. The practitioner turns the patient’s knee into internal rotation, which will cause inferior motion of the right pubes. Turning the patient’s knee in an external rotation direction will cause the right pubes to move in a superior direction.

6. Hold in the position you wish to accomplish for 3 to 5 seconds or until the tissues have released.

7. Release and evaluate.

**Sacroiliac Joint Motion Restriction Treatment FPR**

1. Patient is prone, with a sufficient number of pillows under the abdomen to flatten the lumbosacral joint. Practitioner stands on the left side of the table facing the head of the table.

2. Place a small pillow between the patient’s left thigh and the table. This will provide a fulcrum for the treatment while protecting the thigh from the table’s edge.
3. Monitor the left sacroiliac joint (SI joint) with a finger of your right hand for the position of ease and place your right hypothenar eminence on the left inferior lateral angle (ILA) of the sacrum.
4. Use your left hand to abduct the left leg until the thigh is over the edge of the table.
5. Use your left hand to press the left leg down toward the floor. Simultaneously press your hypothenar eminence down on the ILA to bend the base of the sacrum backward on the left. Apply an upward (cephalad) force to slide the sacral portion of the SI joint along the ileal portion.
6. Ask the patient to take a deep breath and hold it for 3 to 5 seconds or until the tissues have released.
7. As the patient exhales, return the leg to a neutral position and release your pressure from the ILA.
8. Reevaluate motion of the SI joint.

**Obterator Internus FPR**

1. The patient is placed in a prone position.
2. The practitioner monitors the obterator internus with his cephalad hand.
3. The caudad hand is used to flex the knee and elevate it from the table until the cephalad hand senses that the obterator internus enters a position of ease.
4. External rotation is then added until the position of ease is felt.
5. The practitioner applies a force down the long axis of the femur.
6. The position is held for 3 to 5 seconds or until the tissues have released.
7. Return the patient to neutral position.
8. Reevaluate.

**Piriformis FPR**

1. Patient is prone with the practitioner seated on the side of the dysfunctional piriformis muscle.
2. The practitioner markedly flexes the patient’s hips and knees.
3. The practitioner induces rotation of the lumbar spine by abducting the knees in the direction of the tenderpoint.
4. The practitioner can rest the patient’s lower leg on their leg.
5. The practitioner fine-tunes through small arcs of motion until the tenderness is completely alleviated or reduced.
6. Compression is then added down the long axis of the femur.
7. This position is held for 3–5 seconds or until the tissues have released.
8. Return the patient to neutral position.
9. Reevaluate.

**Psoas FPR**

1. Patient is supine with the practitioner standing to the side of the dysfunctional psoas muscle.
2. Physician will monitor the psoas from the area of the AL1 tenderpoint.
3. The patient’s hip and knee of the dysfunctional side are flexed to a point of ease beneath the monitoring hand. The position is then fine-tuned with internal/external rotation and side bending.
4. Once the position of greatest ease is found a compressive force is added through the knee down the femur into the hip.
5. The practitioner further fine tunes the position ease with small amounts of flexion/extension, rotation, and side bending.
6. The position is held for 3 – 5 seconds or until the tissue releases completely.
7. Return the patient to neutral.
8. Reevaluate.

**Tensor Fascia Lata FPR**

The patient lies on their side in the lateral recumbent position with the tight IT band up.

1. With the knee flexed to 90°, the practitioner abducts then extends the upper leg (note this is the set up for Ober’s test of the hip if the patient has tight IT bands when the leg is released it will not adduct).
2. The practitioner stands behind the patient and brings the leg into enough abduction to ease the muscle tissue.
3. The practitioner will apply facilitating force up the long axis of the femur.
4. Next the practitioner tweaks the leg with small amounts of abduction /external rotation to further ease the muscle fibers.
5. Hold for 3–5 seconds or until the tissue releases completely.
6. Return the patient to neutral.
7. Reevaluate.

**Quadratus Lumborum Counterstrain-Lateral Recumbent**

1. The patient lies lateral recumbent on the opposite side of the tenderpoint and the practitioner stands behind the patient.
2. The practitioner flexes the patient’s knees and slightly extends the hip.
3. The practitioner induces marked abduction of the hip.
4. The practitioner slides a knee under the patient’s abducted leg for support.
5. The practitioner induces external rotation by softly pushing the foot towards the table.
6. The practitioner fine-tunes through small arcs of motion until the tenderness is completely alleviated or reduced.
7. Once the position of greatest ease is found a compressive force is added through the knee down the femur into the hip.
8. The position is held for 3–5 seconds or until the tissue releases completely. After treatment is complete reassess the restriction.

**FPR for Anterior Lumbar Counterstrain (AL1, AL2, AL3, AL4, AL5, Iliacus)**

AL1 is medial to the ASIS
AL2 is medial to AIIS
AL3 is lateral to AIIS
AL4 is inferior to AIIS
AL5 is 1cm lateral to pubic symphysis and slightly inferior to the prominence
1. The patient lays supine on the table and the practitioner stands on the side of the tenderpoint.
2. The practitioner flexes the knee and flexes the hip to flatten the lumbar spine.
3. The practitioner places the caudad hand on the tenderpoint to be able to monitor and the cephalad on the flexed knee.
4. The practitioner is then able to add more hip flexion with either internal or external rotation. A little abduction may be needed to fully relax the tenderpoint.
5. The practitioner then applies a posterior pressure along the long axis of the femur towards the table.
6. The practitioner feels for a melting/softening of the tenderpoint and then relaxes the compression and moves the patient’s leg back to neutral.

References

