Introduction to manipulation

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Origins

The art of manipulation was known to Hippocrates and the physicians of ancient Rome, and has passed down a long line of medical manipulators and bonesetters to present day practitioners; osteopaths, physiotherapists, chiropractors and manipulating physicians and surgeons. Osteopathy and chiropractic, unlike physiotherapy, at present remain outside orthodox medical practice in the UK.

The subject has always been contentious, often acrimonious, with much factional and interprofessional rivalry, but in the late 20th century the practice of manipulation is finally achieving scientific respectability through the application of biomechanical principles and recent advances in neurophysiology, together with a serious attempt to prove efficacy through controlled randomized clinical trials. Thus osteopathy and chiropractic may yet be extended a guarded welcome into the orthodox medical fold.

This paper will describe briefly the terminology used in manipulation and discuss patient assessment, indications for treatment and the common manipulative techniques. A review of present knowledge of the physiological effects of manipulation will accompany a discussion of clinical outcomes based upon data from clinical research.

Osteopathy and chiropractic were both founded in the USA during the late 19th century. Andrew Still, the father of osteopathy, based his treatment on the belief that all symptoms arose from abnormalities of segmental motion, whilst David Palmer, the founder of chiropractic, was convinced that symptoms of disease in other body systems developed from changes in vertebral alignment.

Within orthodox medicine, physiotherapy is acknowledged to play an important role in the management of musculoskeletal problems. Central to practice is the use of manual skills, including massage and passive joint manipulation. Physiotherapists may work either independently or in conjunction with their medical manipulator colleagues, whose work extends to manipulation under anaesthesia. This procedure will not be covered here.

Techniques have developed along similar lines in each of the professions, regardless of the philosophy governing their use, with only minor differences of interpretation.

Terminology

Any discussion amongst manipulators is hampered by a vocabulary that means different things to different people, the gulf never greater than between the general public and the medically qualified. Perhaps the most accurate description of manipulation is given by the Oxford Dictionary: 'to work with the hands, to handle or manage'. Many lay people erroneously believe that the term implies the use of fast jerking techniques, and carries with it the stigma of 'quackery' or connotations of 'putting bones back' by the use of large amounts of ill-advised force and small amounts of brain power.

Those who employ manual techniques as the tools of their trade use the term manipulation to encompass a wide variety of procedures from the most gentle to very vigorous, including both low- and high-velocity applications (Figure 1). The wealth of techniques available is described fully and illustrated elsewhere.

Manipulative therapy procedures are applied passively to the patient who does not actively participate apart from giving consent. These may be usefully subdivided into (1) soft tissue techniques, (2) mobilization techniques applied to joints, and (3) manipulation or high-velocity thrust techniques also applied to joints.

![Figure 1. The types of manipulative therapy ranked according to force applied and frequency of use. HVT, high-velocity thrust](http://bjsm.bmj.com/)

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Soft tissue techniques

Traditional massage falls into this category and is applied to muscles, fascia and ligaments. These techniques are dealt with thoroughly elsewhere8-10, and this paper will only discuss the manipulation of joints.

Mobilizations

These techniques are amongst the most common used in the treatment of musculoskeletal problems and are either repetitive oscillatory movements, or sustained stretches at the end of range. Such procedures remain under the patient’s control. Mobilizations can be divided into localized ‘specific’ procedures, and more generalized techniques.

As the name suggests, specific techniques act directly on the joint involved, with the operator using anatomical structures as levers. Spinous and transverse processes of the vertebral column are frequently employed as short levers (Figure 2) to produce translatory gliding and rotation of neighbouring articular surfaces in the accessory range of movement11,12.

In a peripheral joint, the proximal bone of the articulation needs to be carefully fixed so that its distal partner may be moved, e.g. in the talocalcaneal joint the talus is fixed so that the effects of a translatory glide of the calcaneum are localized (Figure 3), and the scapula is fixed by the patient’s weight to allow translatory gliding of the humeral head in the glenoid fossa (Figure 4).

Non-specific generalized techniques, such as rotation of the lumbar spine, use longer levers offered by the shoulder, pelvic girdle or limbs, and produce their effects over several joints. The force required in these situations is proportionately reduced by the greater leverage13.

Manipulation or thrust techniques

A manipulation consists of a single high-velocity thrust applied to a joint, or series of joints and associated soft tissues. The aim is usually to restore lost movement and to relieve pain. These techniques are only performed on a relaxed patient. A manipulative thrust technique momentarily takes the joint further than its normal physiological range. Accurate localization of the joint position before the technique, followed by a skillfully applied thrust, will result in a movement which is so fast that it is complete almost before the patient knows it has begun14.

This procedure is sometimes indicated when a joint fails to achieve full mobility after mobilization. Although used mainly in the treatment of spinal problems, manipulation can be employed to treat the shoulder or sacroiliac joints, and the small joints of the hand and foot14.

Figure 2. Pressure applied through a spinous process in the lumbar spine in a posteroanterior direction

Figure 3. Translatory movement of the talocalcaneal joint

Figure 4. Translatory movement of the glenohumeral joint

Examination and assessment

Every manipulator, regardless of his professional origin, must identify accurately the site of the lesion before treatment. Manipulative therapy aims to be effective and efficient, but above all safe. The good practitioner will meticulously examine the patient to exclude contraindications (Table 1) and identify the structure causing the problem, be it a joint, ligament or muscle6,15.

The contribution of James Cyriax to the analysis of musculoskeletal problems is invaluable. Most manipulators examine patients using methods developed by him, although upon this foundation many refinements have been added15. The distribution of symptoms and behaviour of pain at rest and during activity through a 24-h period are noted, together with a detailed account of the onset.

This information is interpreted by the therapist and further tests conducted until the faulty structure is located. In particular, discrepancies between active
and passive movement are identified, measured and analysed. The importance of this process cannot be underestimated as it forms the baseline for implementing and evaluating all subsequent manipulative procedures.

### Indications

Manipulative therapy is indicated by pain and dysfunction of musculoskeletal origin, either of longstanding or of recent onset, occurring in vertebral and peripheral joints. Manipulation is not the panacea for every complaint of mechanical origin, but skilfully employed at the correct stage, it can yield considerable benefit. 

Most joint problems can be placed into two categories, those which will respond quickly to treatment, e.g. an acute wray neck, and those whose pathology or injury generally respond slowly, e.g. whiplash injury. The so-called ‘miracle cures’ frequently extolled by sufferers are often problems readily amenable to manipulative procedures. Often the manipulator will recognize that prompt assessment and an accurately localized intervention will hasten the healing that would eventually occur naturally. Occasionally unscrupulous operators will exploit this to preserve the mystique of manipulation.

### Contraindications

The manipulator who has full knowledge of the patient’s medical status knows clearly those situations in which thrust techniques are absolutely contraindicated and those where mobilizations are unwise.

Diseases and injuries of the bone and joints completely contraindicate thrust techniques. Gentle mobilization and soft tissue procedures can be used safely in situations where thrust techniques could not, such as severe nerve root entrapment syndromes (Table 1).

### Physiological effects

The effects of manipulation upon physiological mechanisms remain inadequately investigated experimentally. Some data exist and the important contributions are reviewed briefly below.

#### Relief of pain

The pain-gate theory and recent advances in articular neurology offer a possible physiological explanation for the analgesic effects of manipulation in the treatment of pain and muscle spasm. Large diameter afferent fibres embedded in the joint capsule and associated ligaments are stimulated by the tension produced by manipulation. This activity inhibits the small diameter nociceptor afferent input to the ascending pathways in the spinal cord, thus reducing the experience of pain at a cortical level. Reflex protective muscle spasm, frequently a result of pain, will clearly reduce as pain subsides, thus reducing discomfort further.

However, Zusman challenges Wyke, reporting electrophysiological studies on cats and primates that show insufficient numbers of large diameter joint afferents are stimulated by oscillatory passive movements to reduce joint pain by pain-gating. Hence passive movements performed on an inflamed joint are likely to stimulate rather than inhibit nociceptor activity. These findings lead to the conclusion that the analgesic effect of passive joint movement is mediated by the endogenous opiate neurotransmitters active in the descending pain suppression mechanism.

A further alternative view is offered that an effective, albeit temporary, decrease in the perception of pain occurs by inhibition of reflex muscle contraction through the stimulation of joint afferents by an end of range passive movement.

#### Increased joint range

Where resistance to movement is due to tissue tension rather than pain, such as the contracture of a capsule or ligament after immobiliation, treatment is aimed at elongating these structures to restore joint mobility.

The force required to stretch a ligament from zero tension to failure, and the deformation which results, can be depicted on a stress–strain curve (Figure 5). This shows that the ligament exhibits first elastic and then plastic behaviour before failure, and that this represents different stages of collagen deformation. The ‘toe’ phase and ‘linear’ phase lie within the elastic region, and elongation of a normal ligament under these conditions is completely reversible.

In the toe phase, single collagen fibres at rest are usually corrugated. The sinuous shape adopted is referred to as ‘crimp’. When stress is applied to a collagen fibre, the initial effect is to straighten the crimp and ‘take up the slack’ (Figure 5). During the ‘linear phase’, under a continued slow sustained stretch, the normally oblique lattice work of collagen fibres realign themselves in the direction of the force applied. Proteoglycans (large protein molecules) and
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water are displaced and bonds within individual collagen fibres become strained.

If further stretch is applied, the structure displays a characteristic ‘plasticity’ (Figure 5) at the point where

![Stress-strain curve for a ligament](image)

Figure 5. Normal stress-strain curve for a ligament

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Table 2. Comparative trials of spinal manipulation

<table>
<thead>
<tr>
<th>Authors</th>
<th>Year</th>
<th>Number in trial</th>
<th>Duration of symptoms</th>
<th>Control treatment</th>
<th>Study treatment</th>
<th>Results</th>
</tr>
</thead>
</table>
| Berquist-Ullman and Larson | 1977 | 217             | <3 months            | SWD               | 1. Back school  
2. Physiotherapy (including manipulation) | 70% better in 2 months. Treated groups improved faster. Back school group had less sickness absence |
| Coxhead et al.        | 1981 | 334             | Average 14 weeks     | SWD and back care talk | 1. Manipulation/mobilization  
2. Exercises  
3. Traction  
4. Corset | Manipulation group had significantly less pain. More treatment led to more improvement |
| Evans et al.          | 1978 | 32              | >3 weeks             | Cross-over design | Analgesics and manipulation | Significant results in group who had manipulation first. Pain less, mobility increased |
| Fisk                  | 1979 | 20              | <35 days             | 10 normal subjects | Non-specific manipulation | Significant improvement in SLR in back pain subjects after manipulation |
| Glover et al.         | 1974 | 84              | +7 days              | Untuned SWD       | Non-specific manipulation | Manipulation group improved immediately, otherwise results not significant |
| Hoehler et al.        | 1981 | 95              | 2–3 weeks            | Massage            | Rotational manipulation | Manipulated patients had less pain |
| Mathews et al.        | 1987 | 513             | 1–3 months           | 1. Local anaesthetic  
2–4 months  
3. Heat  
4. Local anaesthetic | Sclerosant injection  
Manipulation  
Traction  
Epidural injection | Non-significant result due to small numbers |
| Rasmussen             | 1979 | 24              | 2 weeks              | SWD               | Manipulation | 30% difference in recovery rate after 6 days  
At 3 months, treated group had significantly less pain |
| Sims-Williams et al.  | 1978 | 94              | Not stated           | Microwave diathermy | Mobilization/manipulation | Treated group had less pain, felt treatment helped and could do light work |
| Sims-Williams et al.  | 1979 | 94              | Significantly longer than 1978 study | Microwave diathermy | Mobilization/manipulation | Results not significant |

SLR, straight leg raise; SWD, shortwave diathermy

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Psychological effects

Undoubtedly the psychological effect of skilful handling and the feeling that the manipulator has located the spot exerts a powerful placebo influence that contributes to the potency of manipulative procedures. This remains unquantified. 

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Clinical results

Research seeking to evaluate the effectiveness of manipulative therapy to peripheral joints is scarce, with the majority of trials addressing the problem of low back pain. Research into the effectiveness of manipulative therapy for low back pain has so far failed to demonstrate a long-term benefit significantly better than for other forms of treatment, or indeed of nature alone. There is little evidence that manipulation helps those with severe or chronic back problems24, although a non-blind trial comparing chiropractic and hospital outpatient (physiotherapy) treatment, in which both groups used manipulation, concluded that chiropractic confers a long-term benefit in severe and chronic pain when compared to hospital management25. However, the validity of these results has been questioned because of flaws in the methodology26.

Adequately randomized and controlled clinical trials of spinal mobilization and manipulation have shown a definite, short-term improvement in pain, movement and functional ability, whilst longer term effects are less clear. Direct comparison between the many studies is complicated by the combination of manual therapy with other treatments27. Manipulation relieves pain and increases mobility more rapidly in those patients whose symptoms have a short history (Table 2)28–33.

A study of cervical manipulation showed that frequency and intensity of migraine, and subsequent disability, was improved with manipulative therapy. Manipulative thrust techniques were not significantly more effective than mobilization alone, and manipulation or mobilization by chiropractors did not produce results that were significantly better than mobilization by physiotherapists27.

Evidence exists supporting the use of passive movement of immobilized tissue to prevent and resolve joint contractures, connective tissue atrophy and delayed healing28, 39.

Several reasons have been identified for the failure to achieve significant results in clinical trials studying low back pain34, 35. The heterogeneity of the patient group, the subjective nature of pain assessments as a measure of outcome, the interpersonal skills and training of the manipulator, and the impossibility of running a double-blind trial are contributing factors. Single case study methodology may offer a valid alternative for the evaluation of manipulative therapy41.

Conclusion

Manipulative therapy encompasses clinical diagnosis and treatment of musculoskeletal pain and dysfunction. A thorough initial analysis of the patient's problem, accurate therapeutic intervention, and evaluation of the subsequent effects is central to the success of this treatment. The therapeutic benefits of manipulative treatment lie mainly with restoration of lost function and the relief of pain. Thus it has much to offer in the management of soft tissue and joint injuries sustained during sport. Clinical trials have shown spinal manipulative therapy to give fast relief of symptoms of short duration, whilst passive movement in general has been shown to have a beneficial effect on immobilized tissue39.

References

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