From the Editors’ Desk:

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FASTER, BETTER, EASIER SOFT-TISSUE MOBILIZATION

In a world of no limits, the ideal soft-tissue mobilization technique would be one that lets you readily and reliably detect and release scar tissue and fascial restriction of the digits, wrist, forearm, elbow, upper arm and even the shoulder. And at the same time, it would reduce or eliminate the wear-and-tear on your own set of hands.

Hand therapist Lori Hiatt, OTR, CHT, who works at OrthoCarolina in Huntersville, N.C., is more specific in her description of the ultimate soft-tissue mobilization process: it would prevent adhesion in post-operative patients by ensuring the tendons glide beneath new scar tissue.

"The problem of adhesion is especially pernicious in those parts where muscle tissue is in short supply, such as on the back of the hand," she says. "There, post-operative scar tissue tends to adhere right down to the bone, thereby preventing the gliding of tendons."

STAINLESS-STEEL INSTRUMENTS

Heretofore, Hiatt, like the majority of hand therapists, has effectively treated upper extremity dysfunctions with the tried and true-myofascial release, cross-friction, scar massage and other methods-despite the physical demands on their own extremities. Now, it seems Hiatt and a growing number of therapists across the country are discovering an approach known as instrument-assisted soft-tissue mobilization (ISTM) that comes about as close to ideal as any technique thus far.

ISTM, developed in 1991, entails use of specially designed stainless-steel instruments - in conjunction with a variety of motions and pressures and a carefully laid-out treatment protocol. It permits soft-tissue mobilization's objectives to be achieved more efficiently and with less physical exertion, according to advocates.

"Instrument-assisted soft tissue mobilization has been very beneficial in my practice," says Gretchen L.
THE HAND

27 Bones
12 Muscles
22 Joints
25 Tendons

1 Pain Reliever

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Maurer, OTR/L, CHT, owner of Hand Rehabilitation of Hampton Roads, Inc., a four-office enterprise based in Norfolk, Va. "I often use ISTM in place of the manual soft-tissue mobilization techniques I had been relying on previously.

"By working with the instruments, I can accomplish more in less time during each visit".

"Also, the instruments are very easy on my hands and I don't fatigue or experience thumb-joint pain administering therapy as I did in the days when I had only my hands to use."

Further, Maurer can see more patients during the course of a day because of the time-efficiencies gained from use of the instruments.

Hiatt echoes Maurer's sentiments: "It's amazing how easy ISTM makes identification of restrictions that cannot be detected with your unaided hands," she says. "Then, when you're performing the actual therapy with the instruments, they let you work down deeper than you can with hands alone.

"I'm amazed too at how people get better quicker when ISTM is used."

SUITE TO MANY INDICATIONS

Therapists find that integrating ISTM with one's regular retinue of manual soft-tissue mobilization techniques proves a simple matter. "I'm using ISTM on virtually every type of case I see - post-operative tendon repairs, hand fractures, wrist fractures, you name it," says Hiatt. "The exception is the patient who is very early post-op and his or her skin has yet to regain sufficient integrity to be worked on."

Hiatt reports excellent results using the ISTM with high risk patients, preventing complications from adhesions. "No matter what you do, scar is still going to form," she says. "However, I can count on ISTM to keep things moving along a lot better."

Mary Sue Tank, OTR, CHT, staff therapist at St. Vincent Physical-Occupational Therapy Center in Carmel, Ind., has been an ISTM fan since 2000. She reports that the technique is useful for ameliorating lateral and medial epicondylitis, lumbral strain and thumb adductor strain.

Therapists who've adopted ISTM typically don't hesitate to incorporate the tools in as many patient treat-

Continued page 4

In The Spotlight ....

Dana Eber OTR/L, CHT

Q: What school did you attend?
A: I received my undergraduate degree in psychology from the University of Florida and my masters degree in Occupational Therapy from the University of St. Augustine for Health Sciences.

Q: Why does hand and upper extremity rehabilitation interest you?
A: Hands are one of our most useful tools for everyday living. They help us care for ourselves and for others, they help us communicate as well as create. To help people return to these activities independently is very rewarding.

Q: What state do you practice hand rehabilitation in?
A: Florida....... Aventura Orthopedic Care Center

Q: Q: What part of your job do you find most challenging?
A: I work in a fast paced Orthopedic Center along side a hand surgeon who sends us many challenging cases with various complex injuries. Managing this volume of patients can be challenging at times.

Q: What part of your job do you find most rewarding?
A: Paraffin Unit- $59.99 Theraputty- $5.95
Seeing the look on a patients face when they re-learn how to hold a coffee mug, sign their name, or turn a key.......... PRICELESS

Q: What area of your expertise do you want to perfect?
A: Modalities- Even though I had a short weekend course in school and listened to a few conference lectures, I feel there is so much more to learn. I am a big believer in the... continued on page 6
ment plans as possible - or to begin their usage at the earliest practical juncture.

"I like to start in with ISTM as soon as possible, preferably on the patient's first visit and continuing with each visit afterward," says Hiatt. "I generally stop toward the final few visits in order to focus on postural and ergonomic exercises and function instruction."

**DIAGNOSTIC TOOL, TOO**

ISTM can be administered in a variety of ways, which is important because not every patient responds to the same maneuvers.

"Part of the magic of the tools," says Hiatt, "is that you have so many options for ways to use them. So, if one technique doesn't seem to be having the effect you're looking for, you can try another. And if that doesn't work, you can try another and another and another. Eventually, in all probability, one of them will provide the result you want."

Upon discovering the one approach that works best for the patient in question, Hiatt notes it in her chart and then uses that particular method every visit thereafter.

Intriguingly, ISTM plays a dual role, in that it is as much a diagnostic aid as a therapy tool.

"We know the general location of the problem, and ISTM allows the therapist to identify specific restrictions that may not be felt by the unaided hand," says Maurer.

To illustrate, Maurer describes the steps she takes in preparing to work on a lateral epicondylitis patient. "Prior to initiating the instrument-assisted technique, moist heat is applied to soften the tissue," she says. "A cream is then applied to allow the ISTM tool to glide more easily over the skin. Then, an ISTM tool known as the half-moon is used to scan below the surface of the skin to assess the presence and extent of fibrosis.

"I sweep the scan tool both proximally and distally to identify adhesions and fibrosis that may be felt in only one direction."

As she scans, Maurer asks the patient questions to elicit feedback that will be helpful in the detection process.

"I ask if pain is felt when I work in a specific area or what it feels like to them - for example: gristly, bumpy, rope-like," she says.

---

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benefit of modalities and hope to broaden my knowledge base.

Q: What suggestions do you have for therapists preparing to take the hand therapy exam?
A: BUY THE PURPLE BOOK!!! And buy Exploring Hand Therapy’s (EHT) comprehensive study guide! But just as important, try to find a study group. You can always learn from other people or at least reinforce what you may already know.

Q: Do you have a tip, trick or just some words of wisdom you can share with us?
A: (A tip for your patients): "You can catch more bees with honey than vinegar". Just use a little psychology to turn those problem patients into perfect patients.

(A trick for splinting): Just drizzle a few drops of Goo Gone on your scissors before cutting anything sticky, ie velcro or padding. Your scissors will come out adhesive free.

Q: What is your favorite diagnosis to treat?
A: Any diagnosis where I can utilize my artistic tendencies to fabricate funky splints.

Q: What do you do when you are not consumed with hand therapy?
A: I sit on the Fine Arts Board of Miami Beach where I produce the 'Miami Beach Festival of the Arts'. I am the Local Artist Committee Chair assisting emerging artists in the community. I also co-chair and founded "Create For A Cure", and art auction benefiting the American Cancer Society.

Q: How did you find EHT? What do you like about EHT?
A: Through networking at meetings. EHT is a one stop shop for continuing education, study materials, networking, and sharing knowledge, tips and tricks.

Thank you Dana!!
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Prices vary depending on Media (CD, DVD, Internet) -- above list is not complete-- only a sample of our course variety.
**Need to serial cast a patient?** We have a great tip we just learned from Paul Bonzani OTR/L CHT in EHT’s modalities course. Before you apply the plaster of paris, dip the patient's finger in paraffin and let it cool. Then apply the cast to the PIPJ. The paraffin creates a “sleeve” for the splint turning it into a removable finger cast/splint.

**Treating CRPS/RSD with splints.** An important tip is to know up front what your splint goals are to prevent the splint from becoming a crutch. If the patient is using the splint 24/7 he/she may end up stiffer decreasing functional outcomes. Make sure the patient understands your splinting regime and why you are splinting. Remember, educate, educate, educate with CRPS patients.

**Next splint tip is to always heat velcro hook** before you stick it to the splint - that way it will be less likely to pull away from the splinting material. If it still wants to pull away you can use a solvent and this will bond it even more. Materials that have a coating will have more problems with the velcro sticking to the plastic.

**When assessing the length of your straps,** make sure your straps are long enough to cover all the sticky back velcro. This makes for a more professional looking splint and you can avoid the frustration your patients will experience when they fray their clothing and furniture with exposed velcro. If you make the straps too short the hook will catch on everything and will also get dirty very quickly. If they are too long they roll and become an eye sore. So take the time to put on the perfect strap length.

**Want to avoid the nasty splint smell and limit bacteria growth?** Well, did you know Sammons Preston has the solution with their antimicrobial splinting material. I just used it on a patient with an extensor tendon repair and after 6 weeks the splint still did not have that “Wow - I need a bath” smell. This new anti-microbial protection will not wash or peel off and comes on a variety of commonly used materials. Call them for a free sample NOW: Phone: 1-800-323-5547
Often times I will scan the non-involved skin to let them feel the difference.

GETTING DOWN TO BUSINESS
Maurer indicates that several instruments might be used in treating a specific area. "I stroke with fairly light pressure at first, then increase it as I work deeper," she says.

Applying the right amount of pressure, when using the tools, is crucial. Tank relies on feel and patient feedback to gauge whether she’s overdoing it, not bearing down hard enough, or right on the money. She instructs the patient to tell her if the pressure causes too much pain. If it does, she immediately backs off.

Pain is most reliably triggered and strongly felt when treating scar tissue, experts assert. "Given that scar is painful tissue, I may work the area for only a minute or so," says Hiatt, who shares that a very effective method of using ISTM on scar tissue calls for light, short strokes down each side of the restrictive area, then inward with a lifting or scooping motion."

Tank, meanwhile, likes to switch between sweeping and strumming motions for treating lateral epicondylitis. She describes the sweeping motion as one that's used longitudinally on a muscle, whereas strumming is deep and perpendicular - similar to cross-friction massage technique.

The length of each stroke, if varied, causes a considerable difference in effect. Long strokes, according to Hiatt, are used to acquaint the affected area with treatment at the start of intervention, or to soothe it at the conclusion. Short strokes, on the other hand, concentrate the power of the instruments on the area of restriction.

"No matter what type of motion you use, a goal is to first clear away the superficial dysfunction," Hiatt says. "Only then will the deeper dysfunction become apparent."

SEEING RESULTS
An ISTM session at Maurer’s offices lasts eight to ten minutes; however, it may take several visits before good results emerge. An important element of the treatment protocol, according to Maurer, is to follow each session with a few minutes of stretching exercises.

CONTINUED ON PAGE 13
“Thank you for developing such a “hand saver” of a product... not only welcoming to the client/patient it is appreciated by the therapist.”

Dear Perry,

Wow!!! Prossage makes my life better. I have been using this product for a few months. Deep tissue mobilization, trigger point therapy and especially scar remodeling has never been easier on my hands as the PROSSAGE Heat glides over the targeted area.

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Another great diagnosis I use Prossage with is trigger finger (conservative and post surgical). The deep scar following trigger finger release or the stubborn nodule post surgery diminishes with the effortless ease when I use Prossage Heat. Usually, my thumbs and hands get fatigued but when I use this product my hands are spared as I produce the results I need. Excellent!!

Thank you for developing such a “hand saver” of a product... it is not only welcoming to the client/patient it is appreciated by the therapist. In fact, our clinic had to order multiple bottles of the largest available size so we all can utilize this great product. Again, thanks for making my job easier.

Nancy Falkenstein
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Problem: An employee has been at the same job for 10 years and recently c/o tight muscles, straining, & tingling. FYI: Overall, this employee is deconditioned.
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* Ice massage
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* Stretches
* Vitamins
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"Usually, improvement is seen the very first time the tools are used," she says. "I can often count on seeing improved range of motion on the order of 15% to 20% at the end of that initial usage. Pain also will be appreciably reduced."

Maurer says she continues ISTM until either the patient achieves what she deems sufficient flexibility and movement, or is indicating a substantial decrease in pain.

Only in the rarest of circumstances do the instruments yield little or no improvements in patient condition over time. Even so, Tank contends ISTM ranks among the finest innovations she’s seen during her nearly 35 years in practice.

"ISTM is a very valuable addition to the toolkit I have at my disposal in working with patients," she says. "And I'm not the only one in this center who thinks that. These tools never sit idle during the day because they’re constantly in use - from the moment we open up in the morning until the time we close up for the evening. When something works, you stick with it. This works."

For more information about instrument-assisted soft-tissue mobilization and training courses offered in your area, visit www.grashtontechnique.com, or call 888.926.2727. If you prefer, write to 3833 N. Meridian St, Suite 307, Indianapolis, IN, 46208-4040.)

Mary Sue Tank’s Story

ISTM puts therapists on a new track. Many hand therapists who use instrument-assisted soft-tissue mobilization (ISTM) first learn about it from colleagues. Such was the case for Mary Sue Tank, OTR, CHT, staff therapist at St. Vincent Physical-Occupational Therapy Center in Carmel, Ind.

Actually, the colleague who brought ISTM to Tank’s attention also happened to be her physical-therapist husband. Back in the mid-1990s, he had become a proponent of the instrument-assisted technique. At home, around the family dinner table, he would discuss with Tank the patients he’d seen earlier in the day and talk about the good results he was obtaining with ISTM.

Tank, eventually became intrigued enough by the concept of ISTM that she asked her employer at the time to consider acquiring a set of tools like those her husband was using where he worked.

Unfortunately, her request was
1. A 12 year old girl has bilateral symmetric radial and palmer curving of the tips of her little fingers. What might the diagnosis be?

2. What position should you splint a patient after a boxer’s fracture of the 5th metacarpal neck?

3. After a styloidectomy of the radius what ligament is disrupted?

4. What tissue is responsible for Dupuytrens contracture involving the MP joint?

5. What nerve passes through the quadrangular space?

6. What are blood carrying structures that supply each of the flexor tendons in the digits called?

7. What is the bump on the distal radius termed. Hint: It is used as an anatomical landmark.

8. What is the most effective way to diagnosis RSD/CRPS?

9. Distal radioulnar joint disruption in association with a displaced radial head fracture and proximal migration of the radius describes what injury?

10. List some provocative tests for TOS.

Answers on page 16
Q: What study resources did you use? and I remember one of my study buddies. If yes - was this helpful.

Q: Did you participate in a study group? The evening as well as on the weekends.

Q: How many hours did you put into the exam? Approximately 5 hours per week until Sept. and then it was 10-12 hours per week from Sept. up until the exam.

Q: Did you participate in a study group? If yes - was this helpful?

Q: What other suggestions do you have for future students preparing for the hand examination? When you are studying, and think something isn’t that important and want to breeze over it...Don’t! It will probably be on the test.

Christina DeRoia, OTR/L, CHT
Mayo Clinic - Jacksonville

Thank you very much.
I purchased both practice exams and found them to be helpful in determining my weak areas. Also, the Purple Book 2nd edition was a great study tool the last few weeks before the test.

Thank you both for helping me pass the test and for your dedication to our profession.

Sincerely,
John E. Duffy, OTR/L, CHT!!!

Q: When did you begin preparations for the exam? Formalized studying 6 months before the exam. However, I have been preparing for a career in hands and the CHT even back to my MPT coursework in graduate school, 5+ years ago. I took an elective course in hand and upper extremity the last semester of my program. I also completed a clinical affiliation at the Curtis Hand Center in Baltimore. I had the privilege of working at a very busy hand center with a strong resident/fellow program. We were able to attend weekly lectures/case presentations offered by the chief of the hand/upper extremity division.

Q: How many hours did you put into studying for the exam? Approximately 5 hours per week until Sept. and then it was 10-12 hours per week from Sept. up until the exam.

Q: Did you participate in a study group? If yes - was this helpful?

No, I did not participate in a study group.

Q: What study resources did you use? -Rehabilitation of the Hand; Hunter, MD, Etc. -Hand Secrets; Jebson, MD, Kasdan, MD -Hand Rehabilitation A Quick Reference Guide and Review; Falkenstein and Weiss -Practice Exams offered by Exploring Hand Therapy (EHT) -Self Assessment exams offered by ASHH -In-services given by my CHT colleagues

-CD offered by ASHT
-Attending the Philadelphia Meeting in March
-Clinical Affiliation at The Curtis Hand Center in Baltimore
-EXPERIENCE in the clinic

Q: What resources were most helpful? ***EXPERIENCE!!!

*Rehab of the Hand for knowledge on extensor/flexor tendons.
*Hand Rehab reference guide (Purple Book) and review and the Exploring Hand Therapy practice exams for all other material.

Q: Did you feel prepared for the exam? Actually, yes. That is until I completed the exam.

Q: What else would have been helpful for the different e-stim units, especially TENS.

EXPERIENCE in the clinic.

Q: What other suggestions do you have for future students preparing for the hand examination? Research, explore, and gain access to every resource possible. This is especially true for those clinicians who are not treating hands for the majority of their case load.

Jennifer Thompson MPT, CHT
PRO Physical Therapy - Hand and Upper Extremity Center, Delaware.

Q: What study resources did you use? THE PURPLE BOOK. THE PURPLE BOOK, and oh did I mention THE PURPLE BOOK!

I also bought the Comprehensive Review CD ROM by Nancy and Susan, Rehab of the Hand, Fundamentals of Hand Therapy, and The Interactive Hand. I basically sacrificed buying new clothes for the year to have the best materials out there.

Q: What other suggestions do you have for future students preparing for the hand examination? THE PURPLE BOOK, THE PURPLE BOOK and I forgot one...... THE PURPLE BOOK!

Q: Did you feel prepared for the exam? YES! BETWEEN THE PURPLE BOOK! and the Comprehensive Review CD ROM, I felt like I had it all! (I sound like Whitney Houston) Dana Eber, OTR/L, CHT
Orthopedic Care Center- Aventura, FL
**Answers to Test Your Knowledge**

1. Kirner's deformity
2. MP flexion and PIP extension
3. Radial collateral ligament
4. Pretendinous bands
5. Axillary
6. Vincula
7. Lister's tubercle
8. Clinical exam
9. Essex-Lopresti lesion
10. Adson's test, costoclavicular maneuver, Wright's hyperabduction maneuver

**Pssst! Did you Know............**

****IMAK** has some great products for computer use and CTD's. The Smart Glove is nice because it can be used with either hand. Plus, it provides light support but does not interfere with use of the hand. It is great for conservatively treating carpal tunnel syndrome as the splint cushions and protects the volar wrist. Also, you know how the ulnar wrist can be problematic; well the smart glove protects the pisiform bone preventing and relieving FCU tendinitis. You have got to try this glove. *(see ad on page 4)*

Also another product I have had great success with is the **IMAK** Pil-O-Splint. I have used the elbow Pil-O-Splint often for cubital tunnel and lateral epicondylitis.

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****BTE** has acquired a new name... **BTE Technologies.** Nancy has the BTE Primus and she loves it. She often feels it is like having an assistant with her. Currently, BTE has a trade-in program. You can upgrade and get money for your older equipment until June 30. Call and ask them about their trade in program or visit: www.btetech.com

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refused on the grounds that it would cost too much from the particular source to which Tank had pointed her bosses.

Several years later, when Tank was hired by St. Vincent, she made a similar request. This time, though, it turned out that her new employer was already considering acquiring ISTM tools, only from a different source, the Graston Technique®, whose offerings were significantly less expensive but equally if not more effective than those Tank had previously sought.

Evidently, Tank's was not a lone voice - St. Vincent administrators had been fielding from other employees unprompted requests for ISTM tools, and that's what got the ball rolling on their decision to at least explore the possibility of buying.

Following an evaluation of the Graston Technique products, administrators became convinced the instruments would make a good investment, so they ordered several sets and also arranged for staff to be properly trained, a requirement by the company, prior to purchasing the instruments. Tank was among the first to step forward when the call for training-course volunteers was issued.

That was in 2000. Since then, she and her colleagues have been using the instruments on a daily basis. Numerous out-patient facilities in the Indianapolis-area utilize GT, including Physiotherapy Associates and Community Hospital, which has more than 65 GT-trained clinicians at its five sites.

Lori Hiatt, OTR, CHT, with OrthoCarolina in Huntersville, N.C., discovered Graston Technique instruments for ISTM in October, 2004, while attending an American Society of Hand Therapy conference in Charlotte, N.C.

Impressed by the ISTM demonstration conducted by GT representatives, she volunteered for a demonstration at the convention - and came away a believer. A month later, she attended a formal 12-hour training course. ISTM now is a primary intervention in her day-to-day practice.

Byline for the Graston Technique article: By Scott Smith, freelance writer from the Los Angeles area who specializes in the healthcare field.

Clinicians prefer Graston Technique®

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SEE WHAT THE EXPERTS ARE SAYING...

“I like Graston Technique because it helps me better identify fibrosis on the soft tissue. My patients can feel it too, and they can provide better feedback during the treatment. GT has definitely brought value to my practice.”

—Gretchen Maurer, OTR, CHT, Owner
NORFOLK, VA

“Graston Technique is a great compliment to my hands. The GT instruments help me diagnostically find areas that would be hard to find manually. GT realigns scar tissue, thus relieving patients’ pain and returning them to normal daily activity quickly.”

—Tank OTR, CHT
INDIANAPOLIS, IN

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Researchers. Proven. Innovative. Accepted.
Q: What is a trigger point?
A: Janet Travell and David Simons, "Myofascial Pain and Dysfunction, The Trigger Point Manual, vol 1," define a trigger point as "a focus of hyperirritability in a tissue that, when compressed is locally tender and, if sufficiently hypersensitive, gives rise to referred pain and tenderness."

Q: What are some common trigger points in the upper extremity?
A: There are multiple upper extremity myofascial trigger points which contribute to several pain patterns and syndromes. For example, trigger points in the scalenes, subscapularis and pectoral muscles refer pain distally into the arm.

Q: Please discuss referred pain and some examples in the upper extremity.
A: Referred pain is pain felt at site distant from its source. Upper extremity myofascial trigger points refer pain in specific patterns. For instance, referred pain from a trigger point in the pectoralis minor muscle is located over the front of the chest and anterior shoulder on the same side and may extend down the medial arm, ulnar border of the forearm and fingers.

Q: What are the various treatment techniques that can be used to treat trigger points?
A: A variety of methods are used to treat trigger points, including ischemic compression, heat, quick icing followed by a stretch of the involved muscle, and local injections.

Q: Please review the difference between inactive, latent and active trigger points.
A: An inactive trigger point is not tender on palpation and does not refer pain. A latent myofascial trigger point is not painful unless provoked through palpation but may have associated stiffness. An active trigger point is constantly painful and may refer pain at rest as well as with motion.

Q: What is fascia?
A: Fascia is a type of connective tissue. It is a pervasive network throughout the body. Fascia surrounds and invests the organs, vessels and neuromusculoskeletal system.

Q: How is it different from muscle?
A: Muscle is a contractile tissue. Fascia is extensible upon stretch and has varying degrees of elastic qualities, however, it cannot actively contract.

Q: Is massage the same thing as myofascial release?
A: Although some may use the terms massage and myofascial release interchangeably, they are not the same technique.

Q: What exactly is myofascial release?
A: Myofascial release (MFR) is a form of manual therapy used to treat soft tissue dysfunction. There are different MFR approaches. According to Manheim and Lovett in the text, "The Myofascial Release Manual", the myofascia is first palpated to determine the area of restriction or tightness. A sustained, light stretch is applied to the tight area in the direction of the restriction. Some approaches refer to the restriction as a "barrier". The therapist waits for the tissue to relax and then increases the stretch. The process is repeated until the area is fully relaxed. Then, the next area is stretched. The length and direction of the stretch is continually guided by proprioceptive feedback the therapist receives from the patient's body response.

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