OPP3 MFR Continued

Tuesday August 12th, 2025

Dr. Alecia Lentz

~Timing	Topic:
10 minutes	Intro
15 minutes	Demonstration: • MFR seated cervical spine with head/neck • MFR long lever upper T spine with head/neck • MFR long lever thoracic spine with UE
20 minutes • 10 per each student	Practice with Partner
5 minutes	Demonstration: • Release of Anterior cervical Fascia
10 minutes • 5 each student	Practice with Partner
5 minutes	Demonstrate: • Crossed mediastinum MFR
10 minutes • 5 per each student	Practice with Partner
10 minutes	Demonstrate: • Supine pelvic diaphragm MFR
15 minutes • 7.5 per each student	Practice with Partner
5 minutes	Discuss: Wrap up

Objectives:

1. Understand the principles of myofascial release (MFR) as a technique that targets myofascial structures using either direct or indirect approaches, by stacking planes of motion toward ease or bind and maintaining the position until a release or unwinding occurs
2. Differentiate MFR diagnostic criteria from other OMT techniques by emphasizing the relevance of TART changes, restricted range of motion, and fascial preferences rather than full triplanar somatic dysfunction(s)
3. Develop palpatory awareness of subtle fascial motions including rotational ease and tension (as seen in Zink patterns and Thomas Test) to guide myofascial release treatment.
4. Practice and demonstrate the following techniques using MFR principles

Pearls:

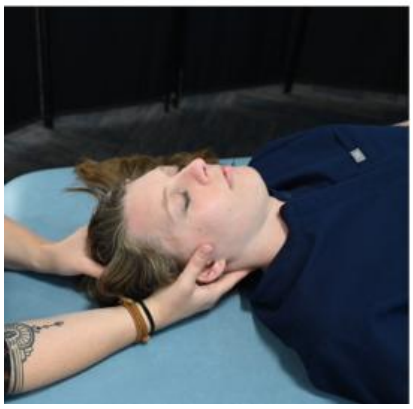
• MFR is guided by palpatory findings of fascial ease and restriction, not necessarily full triplanar somatic dysfunction

• TART criteria especially fascial texture, asymmetry, and restricted range of motion are sufficient for diagnosis in MFR. Fascial assessment emphasizes functional rather than structural findings.

• Fascial preference can be subtle, often experienced as a gentle rotational bias (e.g. a clockwise twist at the inlet or diaphragm) rather than a hard end-feel

• Stacking tissue in planes of motion and holding until release enhances proprioceptive feedback and supports self-correction. Common signs of release include softening, warmth, tissue creep, and unwinding. Some tissues may shift slowly and subtly, be patient and perceptive

MFR seated cervical spine with head/neck



Possible TART Findings/Diagnosis: Rt/Lt/Bilateral cervical TART changes with focus on myofascial tissue
Example Diagnosis: Rt cervical fascial pull medial, inferior, CCW
Patient Position: Seated
Physician Position: Standing behind the patient

1. The physician places one hand along the cervical region with the most significant TART changes, while their opposite hand contacts the vertex of the head
2. The physician then slowly tests superior/inferior, medial/lateral, CW/CCW to determine the directions of ease and restriction
3. The physician then stacks the planes into ease or into the restriction
4. The physician uses their cephalad hand to passively move the head and neck to achieve maximal change in the myofascial tissues
5. The physician can follow the unwind in the myofascial tissue and fine tune adjust as needed.
    a. This technique may also be modified by adding compression, distraction and/or utilizing breath to achieve additional release in the myofascial tissues as needed
6. The physician maintains this position until a release is felt
7. The physician returns the patient to neutral
8. Reassess

MFR long lever upper T-spine with head/neck

Possible TART Findings/Diagnosis: Rt/Lt/Bilateral upper thoracic TART changes with focus on myofascial tissue
Example Diagnosis: Rt thoracic fascial pull medial, inferior, CCW
Patient Position: Seated
Physician Position: Standing behind the patient

1. The physician places their hand along the Rt thoracic region with the most significant TART changes while their opposite hand contacts the vertex of the head
2. The physician then slowly tests superior/inferior, medial/lateral, CW/CCW to determine the directions of ease and restriction/barrier
3. The physician then stacks the planes into ease or into the restriction/barrier
4. The physician uses their cephalad hand to passively move the head and neck to achieve maximal change in the myofascial tissues
5. The physician can follow the unwind in the myofascial tissue and fine tune adjust as needed
    a. This technique may also be modified by adding compression, distraction and/or utilizing breath to achieve additional release in the myofascial tissues as needed
6. The physician maintains this position until a release is felt
7. The physician returns the patient to neutral
8. Reassess

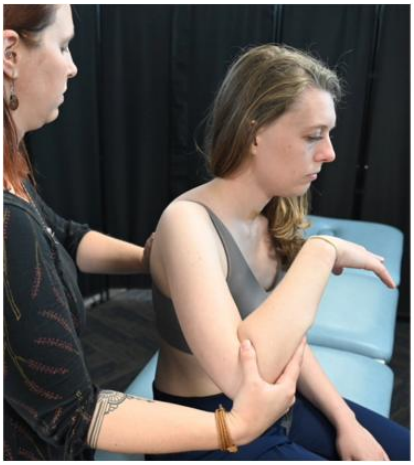
MFR long lever thoracic spine with UE

Possible TART Findings/Diagnosis: Rt/Lt/Bilateral upper thoracic TART changes with focus on myofascial tissue

Example Diagnosis: Rt thoracic fascial pull medial, inferior, CCW

Patient Position: Supine

Physician Position: Standing or seated at the side of most significant TART findings



1. The physician places one hand along the Rt thoracic region with the most significant TART changes and will monitor here while their other hand contacts the UE, cupping at the distal humerus and elbow with the patient's hand draping over the physician's forearm
2. The physician then moves the UE into F/E, aBduction/aDduction, IR/ER – stacking these vector forces through the tissues to achieve maximal ease of the arm, shoulder, torso, and ultimately the identified TART changes
3. The physician follows the unwind in the myofascial tissue and fine tune adjust as needed.
   a. This technique may also be modified by adding compression, distraction and/or utilizing breath to achieve additional release in the myofascial tissues as needed
4. The physician maintains this position until a release is felt
5. The physician returns the patient to neutral
6. Reassess

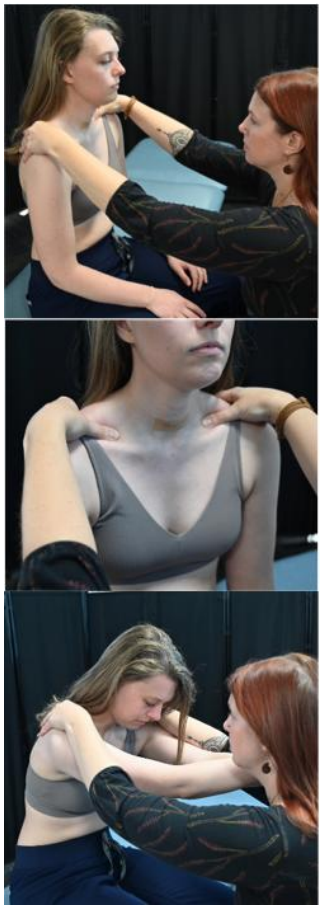
Release of the Anterior cervical fascia

Possible TART Findings/Diagnosis: Rt/Lt/Bilateral anterior cervical TART changes with myofascial tissue, restricted motion of the thoracic inlet, lymphatic congestion

Example Diagnosis: Rt anterior cervical fascial pull lateral, rotated right

Patient Position: Seated, slightly higher than physician

Physician Position: Seated, slightly lower than patient



1. The physician places their thumbs superior to the clavicles, lateral to the SCM attachments in a posterior and inferior direction
2. The patient gently flexes forward, placing their forearms/hands on the physician's shoulders, while the physician's thumbs gently advance posteriorly and medially toward the trachea
3. The physician's thumbs are approximated just enough to engage and hold the anterior cervical fascia
4. The patient slowly straightens (one vertebra at a time), while the physician maintains engagement of the anterior cervical fascia
   a. The patient then can slowly lift their head and neck to further stretch the fascia
   b. Optionally, the physician can instruct the patient to take a deep breath allowing the physician to further engage the fascia
5. The physician holds until a release is felt
6. The physician gently releases their contact
7. Reassess

Crossed mediastinum MFR

Possible TART Findings/Diagnosis: Restriction or ease of motion superior/inferior, Lt/Rt, diagonal or CW/CCW at different depths

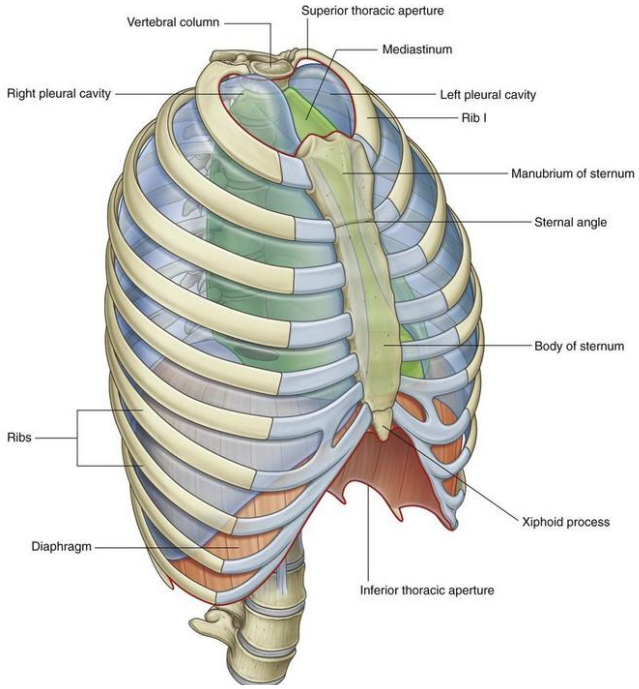
Example Diagnosis: Superficial mediastinal fascial restriction inferiorly and CCW

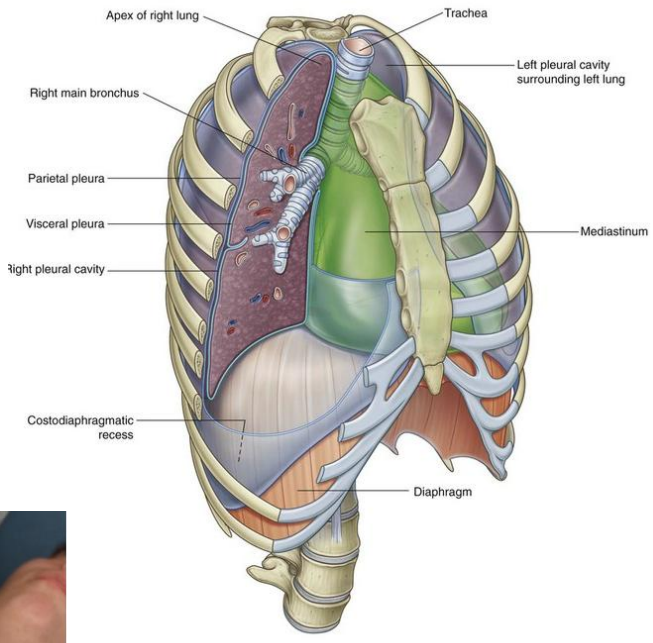
Patient Position: Supine

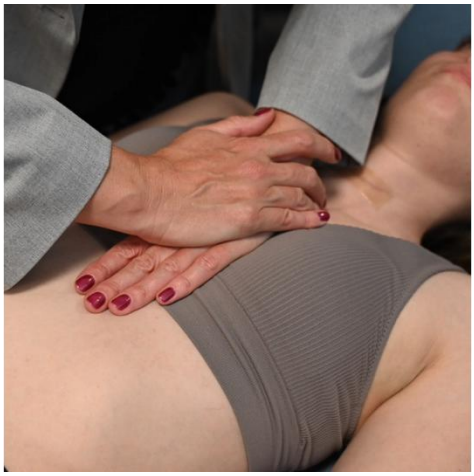
Physician Position: Standing at patient's side

Treatment:

1. The physician places their cephalad hand on the sternum on a diagonal pointing inferiorly with fingers toward the splenic flexure, and their caudad hand on top with fingers pointing toward the opposite shoulder, making an "X"
2. The physician gently and steadily compresses posteriorly, palpating the tensions as they slowly move through the layers of fascia anterior and posterior to the sternum
    a. The physician fine-tunes their pressure, and intention to get deeper into the mediastinum, where they may detect individual structures such as the pericardium, trachea, main stem bronchi and their surrounding fascia
3. The physician then slowly tests superior/inferior, Lt/Rt, diagonal glides and CW/CCW motions
4. The physician then stacks into the ease or restriction in all planes
5. The physician holds until a release is felt
    a. Additionally, the physician can instruct the patient to take a deep breath or add a subtle vibratory activating force to facilitate further release
6. The physician gently releases their contact
7. Reassess







[Thorax | Basicmedical Key]

Supine pelvic diaphragm MFR

Possible TART Findings/Diagnosis: Rt/Lt/Bilateral inhaled position or exhaled position pelvic diaphragm

Example Diagnosis: Lt exhaled position (exhalation) pelvic diaphragm

Patient Position: Supine w/bilateral knees flexed

Physician Position: Seated at left side of table

Diagnosis: Following steps 1 and 2 below. The physician then evaluates the motion of the pelvic diaphragm by asking the patient to inhale and exhale. With inhalation the pelvic diaphragm should descend and press inferiorly on the physician's fingertips. As the patient exhales the pelvic diaphragm should ascend and move superiorly away from the physician's fingertips.

If the pelvic diaphragm does not descend during inhalation this is considered an exhaled position pelvic diaphragm. If the pelvic diaphragm does not ascend during exhalation, this is considered an inhaled position pelvic diaphragm.

Treatment:

1. The physician, with a neutral wrist, contacts along the medical aspect of the Lt ischial tuberosity with their finger pads
    a. To increase patient, comfort the physician can place a towel and/or pillow between their posterior hand and the patient's body
2. The physician then moves their finger pads just medial to the ischial tuberosity, contacting the ischiorectal fossa and gently directs a cephalad and lateral palpation of the ischiorectal fossa/pelvic floor
3. The physician engages the left restrictive barrier by moving their fingertips cephalad and lateral. The physician instructs the patient to inhale and maintains their position. This discourages further inferior movement of the pelvic floor. As the patient exhales, the physician further engages the barrier in a cephalad and lateral direction
4. The physician continues to follow steps 3 and 4 until no further release is appreciated
5. The physician slowly and respectfully removes their contact
6. Reassess both sides

    Diagnosis and treatment can be combined; you can maintain contact and start treating after diagnosis