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Osteopathic Manipulative Treatment and Other Immune Related Diseases Including Long Haul Covid: Interview with Dr. Kim Sing Lo, Part II

Editor: *The current newsletter contains another article on Covid-19 and a brief introduction to Long Haul Covid. In a future NEMSN newsletter there will be a more lengthy article on Long Haul Covid including symptomology and potential treatments. However, in this current interview with Dr. Lo we asked specifically about Long Haul Covid and other immune related diseases and how OMT can be used in the treatment of such patients. Therefore we hope that you will find this second interview with Dr. Lo informative and useful as you continue to deal with EMS-related symptoms, and other immune related disorders. In the first interview, Dr. Lo discussed some aspects of OMT and EMS, but in this second discussion he addresses the more practical issues of OMT application to patients with problematic Immune Systems.*

1. Do you have any experience dealing with patients suffering from autoimmune disorders such as Multiple Sclerosis?

Answer: I have treated a small number of Multiple Sclerosis (MS) patients. I have mentioned previously that my initial approach to any patient is to consider each one as a "blank slate" irrespective of their condition. However, I do obviously consider any pre-existing conditions in my follow up sessions by paying more attention to disease specific areas of interest. For instance in MS patients the brain and myelin sheath are obvious points of concern and focus. Symptoms that manifest in dysfunctional areas may be a significant obstacle for the body to regain balance (called homeostasis) and start the healing process. The myriad of autoimmune diseases affect different tissues, organs and can be systemic. As previously mentioned MS provides more insults to the nervous system; thus craniosacral treatment is the ideal technique to use on such patients. Normal cerebrospinal fluid (CSF) production, absorption and flow is important to provide optimal nutrient supply and to remove any waste products due to inflammatory processes in the Central Nervous System (CNS). The CSF circulates in a closed space and its subtle flow dynamics depend on rhythmic brain expansion and contraction. The combined nuanced cranial bones and brain movement interactions are critical for uninterrupted CSF flow. OMT practitioners have been able to detect the subtle brain expansion and contraction by hand for many years. It is interesting to note that recently scientists have observed (using powerful magnetic resonance imaging instrumentation) the same respiratory driven brain movements reported by OMT physicians.

Treatment techniques for MS patients will depend on a number of factors. Is the patient in an acute flare up? Does the patient need just maintenance treatment? Does the patient need more symptomatic support? Although craniosacral treatment is the primary approach, it is important to communicate with the patient's body as well as set realistic expectations for the patient, thus ensuring less likelihood of failure. In acute MS flare-ups, it is likely that the patient is

experiencing inflammatory or residual inflammatory responses impacting the nervous system. The craniosacral system is likely in a more dynamic state. This means the amplitude of cranial expansion will be significant, in that it may be faster than normal. “Calming” the craniosacral system will help to more rapidly decrease inflammation. However, a slower but adequate amplitude and rate of brain expansion is necessary to ensure proper CSF flow. An experienced osteopath will fine-tune the cranial rhythmic impulse to an ideal level at the end of each session. Of course, proper cranial venous drainage is also vital for optimal CSF absorption. Occipitoatlantal joint dysfunction is another critical area that affects CSF dynamics. Specific cranial bone dysfunction correction will facilitate better craniosacral movement. A good cranial venous sinus release technique will usually lessen tension in the dura around the foramen magnum, congestion in the cranial venous sinus system and pressure in the cranium. Symptoms like headache, fever, fatigue, neck stiffness and anxiety will improve. Frequently, patients will sleep better after treatment. If an MS patient has vision problems, then checking ocular muscle tension is important. Note that dysfunction or tension in the lesser wing of the sphenoid can add stress to the optic nerve. However, the occipital lobe of the cerebrum requires more careful evaluation using my hands. Balance of the cranial reciprocal tension membrane (falx cerebri and tentorium cerebelli) is necessary. Sometimes, tension from the cerebellum below the tentorium cerebelli may be a factor. MS patients who have balance problems can be helped by temporal bone dysfunction correction, unless there is already nerve involvement. Finally, if an MS patient comes in for maintenance treatment, temporal bone dysfunction is a vital checklist item. The temporal bone is usually the “troublemaker” of the head. If the temporal bone has no dysfunction, CSF flow and cranial venous sinuses drainage are usually adequate, hence MS symptoms may be under better control.

OMT may be of use in the treatment of other autoimmune diseases. For example I have treated a patient with Sjogren’s disease [*Editor’s Note: In Sjogren's syndrome, the mucous membranes and moisture-secreting glands of your eyes and mouth are usually affected first — resulting in decreased tears and saliva.*] The patient reported no dry eyes, dry mouth or lung problems, but occasional joint pain and fatigue. I recommended meditation along with myofascial release. I do not believe that OMT can cure any autoimmune disease, but certainly can provide symptom relief for a variety of such wide-ranging disease conditions.

2. Currently a significant percentage of the US population is suffering from LHC. The situation is compounded by the fact that the medical community neither fully understands the cause of LHC nor can provide effective treatments. Some peer-reviewed literature suggests that LHC is related to Post Viral Syndrome (PVS), which in turn has been related to Chronic Fatigue Syndrome (CFS). How do you think OMT can be applied to patients with LHC, or PSV or CFS?

Answer: My experience with PVS and CFS and PVS patients is also limited. I have treated a number of patients for muscle pain after a cold or acute viral episode. I treated them with OMT, usually with a combination of direct spinal adjustment and quick myofascial release. Typically, each patient recovered quite well and did not require a follow up visit. I also treated a small number of CFS patients that visited me on a regular basis. However, in my opinion their osteopathic dysfunction didn’t change much even though they reported improvement.

Fibromyalgia patients also have a significant amount of fatigue and pain. I suspected that the systems of these patients were overwhelmed by long-term stress, and possible non-confirmed viral infection, compromising their hypothalamic-pituitary axis. These patients reported less pain and less fatigue after OMT therapy.

LHC is obviously a topic of great interest at the moment, since so little is known about this complex condition. I cannot speculate about the possible relationship of LHC and PVS. However, my experience suggests treating LHC as soon as possible before the patient reaches a condition similar to CFS. How would I treat LHC with OMT? Based on LHC symptoms reported by the CDC and peer-reviewed journals, fatigue and muscle weakness are most common along with shortness of breath. If I compare LHC symptoms with pituitary insufficiency, there are some overlapping symptoms. I suspect those LHC patients with fatigue and muscle weaknesses have a low amplitude and rate of movement in their cranial rhythm. Unfortunately, I have not had the opportunity to treat LHC patients. However, in my opinion it is important to consider that the normal physiologic motion of spheno-basilar synchondrosis (SBS) is the key to all healing. Compressions of the fourth ventricle (CV4) will improve the amplitude and the rate of movement of the craniosacral rhythm. Please note that the CV4 technique requires caution in pregnant patients. This technique can potentially induce unwanted uterine contraction if the patient is not ready for labor and delivery. Temporal bone balance will enhance temporal lobe movement and influence the lateral ventricle production of CSF. Decreased cranial venous congestion almost always improves brain fog. Occipitomastoid suture dysfunction correction will decrease tension in the jugular foramen. The vagus nerve is important innervation to the lung and gastrointestinal tract. Phrenic nerve that originates from spinal nerve (C3-C5) is the primary motor supply to the respiratory diaphragm. Occipitoatlantal joint release will insure proper CSF flow between the cranium and the spine. Your medulla oblongata is located at the base of your brain, where the brainstem connects the brain to your spinal cord. It plays an essential role in passing messages between your spinal cord and brain. It's also essential for regulating your cardiovascular and respiratory systems. Dysfunction of the occipitoatlantal joint also produces tension to medulla.

LHC patients with shortness of breath will need additional evaluation of the neck, lower six ribs, and T7 – L3. Note that the superior diaphragm origin is continuous from the xiphoid process anteriorly to inner aspects of the lower six ribs of the thorax, laterally to the 11th and 12th ribs, and posteriorly to the lumbar vertebrae of L1, 2 (left), L1-3 (right). The lower six ribs articulate directly with the corresponding thoracic vertebrae. The relationship of the sternocleidomastoid muscle, Sibson fascia and apex of lung may have bearing on shortness of breath in LHC patients. The respiratory diaphragm is attached to the lower six ribs and indirectly to the lower six thoracic vertebrae. The crura of the diaphragm attaches to as far down as the third lumbar vertebrae via the crura. Any dysfunction in T7 to L3 and lower six ribs can affect the mechanics of the respiratory diaphragm. If the LHC patient was intubated and put on bed rest for a long period of time, any dysfunction at the thoracolumbar junction and lower six ribs should be corrected in ICU or as soon as their physical condition allowed. Proper rib cage and respiratory dynamics may require less pressure from ventilator to expand the lung. Medical care providers often overlook the significance of the pelvic muscular diaphragm upon pulmonary vital capacity. A stiff pelvic diaphragm will descend less during respiratory diaphragm contraction. A more

dynamic pelvic diaphragm will allow more efficient respiratory diaphragm contraction and rib cage expansion, thus facilitating ease of breathing.

The cranial reciprocal tension membrane balance is significant in LHC, with smell difficulties often a symptom. Olfactory bulbs which rest on cribriform plate of the ethmoid bone receive stimuli from the olfactory nerves. The axis of the ethmoid, sphenoid and vomer bones plays a key role in any dysfunction of the upper jaw (maxilla bones) and can significantly affect primary respiration. Tension in this area will also affect the cribriform plate and proper olfactory nerve healing. Congestion will delay clean up from any inflammatory reaction in this area. I believe if we address these areas early after diagnosis of LHC, then patients may recover much faster.

Finally, one aspect of LHC patients that I didn't address was the psychological trauma from fear of death and potential permanent physical disability during the initial Covid-19 infection, aftermath and LHC. Trauma from intubation may cause non-physiological vertical strain patterns in the cranial mechanism. We have seen patients with difficulty falling asleep at night and with brain fog for several weeks after general anesthesia for surgery. A gentle balance of the cranium, the occipitoatlantal joint release with cranial venous sinus release, will usually help patients back to a better mental status. Occasionally, the fascia of the mediastinum is affected. The hyoid bone, all attached muscles and prevertebral fascia of the cervical spine would need rebalancing with the mediastinum to restore the proper rib cage dynamic. In summary, I believe OMT can play a significant role in helping LHC patients by helping to alleviate symptoms and hasten the pace of recovery.

(Please note the opinions expressed in this article are solely those of Dr. Lo and do not necessarily reflect the viewpoint of NEMSN.
Readers should consult their own physicians if concerned about an immunocompromised/overactive immune situation and Covid-19/Long-Haul Covid-19.)