LYMPHO-FASCIA RELEASE AND VISCERAL LYMPHATIC APPROACH TO FASCIA
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‘Harmony only dwells where obstruction does not exist.’

Osteopathic lymphatic technique (OLT) and viscerolymphatic approach to fascia

Osteopaths, in clinical practice, often need to connect to the wholeness of their patient and find a way to quickly and elegantly assess the predicament that disturbs a specific structure. The treatment procedure in a mechanical model is often an approach that takes the tension of the tissue away.

‘Dr. Andrew Taylor Still taught that technique, to be most effective, should be gentle, easy, and scientific.’

Ideally, we should use the most efficient and least invasive techniques, with minimal force, to get to this result.

During the last 25 years, several techniques have emerged from the osteopathic model. Numerous well-known methods use a ‘solid’ model for the physical body, the musculoskeletal framework, and the fascia structure. Osteopathy also covers an entire domain of very different, gentle ‘fluid’ techniques (e.g., cranial or lymphatic techniques) that were at a time considered to be more difficult to teach. These refined techniques allow practitioners to release restrictions in the body’s fluid compartments to reinstate tissue health.

‘... exaggeration of the lesion ...This method is the more difficult of the two [exaggeration and direct methods] and for the instruction of students does not find favor with the author.’

This eternal quest for the body’s reinstatement of a more complete physical healing led to the development of a unified, noninvasive technique with great efficiency for the mechanical structures of the body called Lympho-Fascia Release (LFR). This approach brings together the advantages of the fluid techniques, using OLT, and the benefits of the solid model such as fascia approaches. The marriage of these two modalities can reduce restrictions with a touch that is gentle, efficient, and profound in its application.

‘Somatic dysfunction is an ‘impaired or altered function of related components of the somatic system: skeletal, arthrodial, and myofascial structures and related vascular, lymphatic, and neural elements.’

‘The presence of normal passive motion in one direction of one plane and resistance in the other is presumptive evidence of somatic dysfunctions.’

As osteopaths, we are well versed with the fact that physical restrictions can result from accidents, surgeries, and other trauma and can manifest in the body as pain, edema, inflammation, spasms, loss of mobility, reduced range of motion, and fibrotic tissues. Some of these restrictions can form adhesions and can be very difficult to release.

‘Somatic dysfunctions are accompanied by local inflammation and edema with modifications in blood and lymph flow.’
A conventional approach is to look for these barriers in the body and break through them with a ‘solid’ model that usually involves some degree of force. Still, when we work only on the fascia fibers without moving the tissue fluid, we often have to use a certain stress on these fibers to get the results we want. Though this approach can lead to benefits for our patients, it can also result in moderate to significant side effects including pain, increased edema, inflammation, and eventually the stagnation of lymphatic interstitial fluid that could be associated with scar tissue. Further, some patients may not be able to receive such mechanical techniques if they present acute pathologies, recent surgeries or accidents, bleeding, or simply conditions that make it difficult to touch the client such as fibromyalgia. LFR enable us to softly engage the fascia and fluid simultaneously, releasing efficiently restrictions on the lymphatic interstitial fluid and fascia planes in one motion, avoiding most of the damaging side effects.

‘In adjusting lesions it is obvious that a method which retraces the path of the lesion with a minimum of irritation is highly desirable.’

So how does LFR work? Normally, when we perform OLT we connect with the fluid body and use a very exact stroke that will synchronize with the specific rhythm of lymph, its specific direction, and its specific depth within the relevant area. This stroke, being on the skin with a light pressure, will also naturally engage some of the fascia. By taking the soft touch of lymph drainage just a little deeper, practitioners are able to first engage the fascia then the lymphatic planes concurrently. With this approach, inspired by the osteopathic tradition of balanced ligamentous, the two systems work in tandem to maximize the body’s response and improve patient outcomes.

‘Dr. Sutherland recommended using the inherent forces within the body such as respiration, fluid mechanics, and postural changes to correct the strain. In general, the technique combines a fulcrum introduced by the physician with an activating force provided by the patient.’

‘These principles use the inherent forces of the body to make the reduction; they do not permit the well-known thrust method.’

Essentially, the concept is quite simple. Balance membranous tension (BMT) and balance ligamentous tension (BLT) were presented by W.G. Sutherland in 1942 and 1944, but this time the osteopath will bring the fascia to a point of balanced ease and then let the lymph and extracellular fluid move through relaxed fascia fibers.

‘[Point of balance, neutral point, point of release]. It is the point in the range of motion where the articulation has been carried to the limit of its unrestricted motion and just into the range where tension or resistance is developing.’

Basically, in the point of balance, the facial fibers are in the lowest tension possible within the tissue so we can send significant waves of fluid flow through the tissue. Then we send the lymphatic and interstitial fluids.

‘Balance the membranes first. Do this in whatever fashion is least irritating to the tissues involved and which will give the operator the keenest possible perception of the tissue response.’

The effects are instantaneous. The patient may feel a deep wave going through an area – releasing stagnation, inflammation, and especially deep chronic adhesion. When done correctly, LFR allows the body to create a single powerful wave, called in physics a ‘soliton,’ which can travel throughout the whole body (e.g., healing ‘tsunami’).

A soliton is a nonlinear wave propagation discovered by the Scottish engineer John Scott Russell (1808–1882). The soliton wave is a dynamic balance between the wave’s tendency to spread out (the dispersive effect) and the nonlinear motion (the superior part of the wave moves faster than the inferior parts).

The prime motto of an osteopath is to find the problem, ‘fix it, and let it alone.’ We need to put the tissue at zero pressure for it to reach a balance point. When the tissue is in neutral this way, the wave appears in response to that balance point and the fluid flows naturally, freely. We assist the wave but we don’t create it or force it. We’re not mechanical engineer doing something to the body, we’re simply working with the body’s own intrinsic intelligence and self-healing, self-regulatory mechanisms. That’s where the profound impact of this technique lies. This wave created with gentleness will move through the body’s restrictions.
Knowing the power of this wave, we no longer have to use a lot of force any longer. Just by using the body’s own internal forces, we are able to go deeper into the tissues and reach areas in the body that often cannot be addressed. Like this, we facilitate not only a local release but also a large number of releases all along the path of the wave as it travels through the body interacting with other systems as it comes in contact with them.

There are numerous applications for Lympho-Fascia Release. LFR can be used very successfully for the treatment of chronic pain conditions because chronic pain is frequently an indication of congestion of the lymph associated with fascia restrictions. Because of its effectiveness in reducing scarring and inflammation, this approach also has positive implications for difficult cases including, for example, long-term fibrosis and fibromyalgia. In the case of a patient with fibromyalgia, LFR is an effective approach because it doesn’t create additional inflammation within the body. In fact, LFR is such a gentle approach that it can be effective in treating different acute conditions and is also beneficial when working with the elderly and the young or even our animal companions, all of whom may react negatively to a strong touch.

LFR is also very efficient at treating visceral or fascial dysfunctions. I don’t use it as much for joints; I use other specific fluid articular techniques. A good patient assessment is essential to this technique. Osteopaths often concentrate on key lesions in the body to get a fast and durable improvement. If we only address secondary lesions in our treatment, the lymphatic ‘wave’ won’t stay in place as well. Through proper assessment, we can listen to the body and find what condition the body is holding. We can then release the restrictions or lesions naturally and without a great deal of force.

Though this technique is relatively simple, it’s also very specific in its application. Naturally, when you approach a patient with a soft, noninvasive touch you also have to be very precise with your assessment for the treatment to be successful. In OLT seminars, we work closely with therapists to help them develop the necessary skills for proper patient assessment. We spend a great deal of time learning specific techniques that allow therapists to work with the body’s own consciousness because without the ability to access the body correctly, this highly effective technique can miss the mark.

The real benefit of LFR is that as osteopaths, we don’t have to approach the body with the typical strong ‘no pain, no gain’ approach and work through barriers. Alternatively, we can retrain our hands to start with the lightest touch possible and increase pressure from there as the body dictates. This allows us to release tension in a manner that’s less stressful on our patients and on us. LFR and other light touch applications can also prolong the amount of time that a therapist can practice because they’re easier on the practitioner’s hands and body than traditional manual techniques without compromising the effectiveness of the treatment. In this way, we can develop a new paradigm to healing: a ‘less pain, more gain’ approach for everyone involved.

LFR could seem counterintuitive at first because it’s much less aggressive than some mechanical approaches but it still has the same valuable effects on patients with far less impact on the osteopath’s body. What’s important to understand is that this type of specialization doesn’t limit your practice, it gives more options while prolonging your ability to help others without hurting yourself in the process.

Sometimes releasing barriers in the body can feel like trying to open a strong safe but with the right key, the door will open easily, without force. The LFR is one of those keys that can lead to a more fulfilling osteopathic practice.

“There is a definite difficult in the transition from art emphasis upon the nature and the direction of the bind...to an emphasis upon the nature and direction of the ease ... Both are extremely valuable ... It would seem to demand almost a year for the transition in order to preserve the old skills along with the new.”

As anything else, it takes some time and dedication to integrate this new tool but you may end up using this approach for 95 percent of your fascial and visceral/somatic dysfunctions and end up doing it for a long time because of LFR gentleness, precision, and long-term efficiency.
Visceral applications for osteopathic lymphatic technique

In this chapter we will elaborate a little more on the practical way to contact the viscera, its assessment and treatment using OLT.

Viscera needs to be contacted with respect and non-invasiveness as they are very sensitive and can easily spasm or contract their ring muscles. Wait and let the information come to you rather than invade the visceral tissue. Be sure to be ‘invited’ by the organ. Very gently and gradually connect with the viscera synchronizing with its quality and intrinsic movement.

Diagnosis

Lympho-Fascia Release diagnosis comprises:

- Intraparenchymal (intrinsic) assessment of a visceral organ;
- Assessment of visceral ligaments;
- Assessment of visceral interfaces: the relationship between two organs.

In Lympho-Fascia Release the diagnosis can be done with ease. You may remember that one of the characteristics of a mechanical osteopathic lesion is the fact there is a barrier in one direction of one plane and, in three dimensions, in the opposite direction the tissue always presents the most ‘ease.’

“The presence of normal passive motion in one direction of one plane and resistance in the other is presumptive evidence of somatic dysfunctions.”

Therefore, the diagnosis of the osteopathic lesion will be done with ease and will have two outcomes:

1. The assessment will be often less invasive than when looking for a barrier. Even a slight position on the tissue against the barrier could possibly stimulate sympathetic activity and to some extent may ‘retraumatize’ some tissue.

2. The direction taken with ease for the diagnosis is also the start of the treatment. In the treatment we will take the tissue all the way to the maximum ease and stabilize within the perfect point of balance.

Treatment

Different types of treatment are possible depending on the location, organ, pathology, and age of the patient, etc.

1. Open the surrounding nodes to facilitate lymphatic techniques.
2. Subacute condition: the basic lymphatic stroke of OLT is often used.

3. Chronic condition: Lympho-Fascia Release (LFR) is often used.

**Open the surrounding nodes**

Thoracic organs: we can open group of nodes to facilitate lymphatic techniques including the cervical nodes, axillary nodes, and the receptaculum chyli (cisterna chyli area).

- Abdominopelvic organs: we can add to the locations above the group of inguinal nodes.
- You can also repeat this procedure if needed after the treatment and ‘rinse’ the lymphatic flow.

**In OLT we apply the basic lymphatic stroke**

In the case of acute or subacute inflammation (e.g., acute or subacute laryngitis, sinusitis, appendicitis, etc.) the basic lymphatic stroke is the least invasive and most respectful technique to address these conditions.

The stroke used in OLT is osteopathic as it is very specific in its:

- Rhythm: the lymphatic rhythm defined by science or about 0.1Hz;
- Direction: toward the proper group of nodes;
- Depth: the specific layer of the lesion: skin, mucosa, muscle, fascia, viscera, dura, bone, and so on;
- Quality: the quality of the lymph flow and its potency provides various information about the health of the patient.

Many other techniques can be added such as perceiving a slight lymphatic asynchrony between the left and right side of the body, assessing if the local area is wet or dry as defined by Guyton (a wet area being an area with clinical or infraclinical fluid stagnation\footnote{11}), switching the lymph flow, creating a retrograde impulse, or using an extracellular fluid technique (EFT).

**Lympho-Fascia Release**

Lymphofascia release can be applied to chronic conditions as it addresses the stagnant fluid as well as the chronic adhesions present in many chronic dysfunctions. LFR can be applied within an organ (intraparenchymal), between the organ and its ligamentous attachments, as well as between organs (at organ interfaces).

**Clinical examples**

Below are some simple clinical examples involving the trachea and lungs.

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Open main surrounding nodes

**Figure 47.1**
Open the supraclavicular group of nodes. This can be done facing the patient as shown or when standing at the head of the table. Synchronize with the specific rhythm, direction, depth, quality and potency of the lymph flow as well as its slight lymphatic asynchrony. Image from LDV1 (Lymphatic Applications to Viscera 1) textbook, IH Publishing, 2010, reproduced with permission

**Figure 47.2**
Open the clavicular nodes. This can be done facing the patient as shown or when standing at the head of the table. Synchronize with the specific rhythm, direction, depth, quality and potency of the lymph flow as well as its slight lymphatic asynchrony. Image from LDV1 (Lymphatic Applications to Viscera 1) textbook, IH Publishing, 2010, reproduced with permission

Intraparenchymal/intrinsic assessment

**Figure 47.3**
Assessing cervical intratracheal lesion. In the case of a lesion you can apply LFR: bring the tissue to balance and send the lymph. Image from LDV1 (Lymphatic Applications to Viscera 1) textbook, IH Publishing, 2010, reproduced with permission

**Figure 47.4**
Assessing dysfunction between the thoracic trachea and the main bronchi. Apply LFR if needed. Image from LDV-TA (Lymphatic Applications to Viscera – Thorax/Abdomen) textbook, IH Publishing, 2010, reproduced with permission

Ligaments and interfaces
Figure 47.5
Assessing dysfunction between the cervical trachea and the heart pericardium (tracheopericardial ligament). Apply LFR if needed. Image from LDV1 (Lymphatic Applications to Viscera 1) textbook, IH Publishing, 2010, reproduced with permission.

Figure 47.6
Assessing dysfunction between the thoracic trachea and the heart pericardium (tracheopericardial ligament). Apply LFR if needed. Image from LDV1 (Lymphatic Applications to Viscera 1) textbook, IH Publishing, 2010, reproduced with permission.

Figure 47.7
Assessing dysfunction between the main bronchi or main/secondary bronchi or between smaller bronchi. Apply LFR if needed. Image from LDV1 (Lymphatic Applications to Viscera 1) textbook, IH Publishing, 2010, reproduced with permission.

Figure 47.8
Assessing dysfunction between the lung and left or right bronchi. Apply LFR if needed. Image from LDV1 (Lymphatic Applications to Viscera 1) textbook, IH Publishing, 2010, reproduced with permission.
Box 47.5

Anterior lungs

Open main surrounding nodes:
- Clavicles, axilla, receptaculum chyli

Intraparenchymal/intrinsic:
- LFR: look for intrapleural/intrapulmonary lesion

Ligaments and interfaces:
- Right lung: superior (horizontal) and inferior (oblique) fissures
- Left lung: oblique fissure
- Bronchopericardial membrane
- Interpulmonary ligament

Figure 47.9
Assessing dysfunction between the heart pericardium and the left or right bronchi or secondary bronchi. Apply LFR if needed. Image from LDV1 (Lymphatic Applications to Viscera 1) textbook, IH Publishing, 2010, reproduced with permission

Figure 47.10
Assessing the parietal pleura. The parietal pleura can drain toward the cervical nodes, the internal mammary nodes, the parasternal or paraspinal nodes, the axillary nodes or the receptaculum chyli. Apply LFR if needed. Image from LDV1 (Lymphatic Applications to Viscera 1) textbook, IH Publishing, 2010, reproduced with permission

Figure 47.11
Assessing visceral pleural or intrapulmonary dysfunction. The visceral pleura as well as the pulmonary parenchyma usually drain toward the hilum of the lungs. Apply LFR if needed. Image from LDV1 (Lymphatic Applications to Viscera 1) textbook, IH Publishing, 2010, reproduced with permission
Figure 47.12

Figure 47.13
Assessing dysfunction of the inferior (oblique) fissure of the anterior right lung (ribs 5–6). The same procedure can be relevant to the anterior left lung. Apply LFR if needed. Image from LDV1 (Lymphatic Applications to Viscera 1) textbook, IH Publishing, 2010, reproduced with permission.

Figure 47.14
Assessing dysfunction of the bronchopericardial membrane. Use two locations. This fascial structure is located anterior to the esophagus. Apply LFR if needed. Image from LDV1 (Lymphatic Applications to Viscera 1) textbook, IH Publishing, 2010, reproduced with permission.
Figure 47.15
Assessing dysfunction of the interpulmonary ligament. The interpulmonary ligament usually connects the two pulmonary ligaments. Only one location is inferior (lower part of the mediastinum). The placement of the hands is almost the same as for the lower location for the bronchopericardial membrane. This fascial structure is located posterior to the esophagus. Apply LFR if needed.

References