The Role of Massage in Rehabilitation
By Garry Lavis

Remedial massage therapists are fast becoming more respected in mainstream rehabilitation. In this article Garry Lavis explains why.

The increased prevalence of remedial massage therapy in rehabilitation is due to legitimate paramedical treatments that achieve a desired outcome such as increasing the range of motion and improving circulation via the manipulation of soft tissue (muscles, tendons and ligaments). Accurate assessment and treatment with clearly defined goals that are measurable and reproducible is producing evidence of the benefits of remedial massage therapy.

Rehabilitation is more commonly being offered in a multidisciplinary setting such as clinics, hospitals or the workplace. A multidisciplinary setting incorporates a group of healthcare workers who provide more than one treatment modality or service. Examples include remedial massage therapy, physiotherapy, chiropractic, osteopathy and psychology. With a trend towards natural therapies and wider acceptance within the medical field, remedial massage often becomes the therapy of choice for many clients.

Working within a multidisciplinary setting has a number of advantages for both the remedial massage therapist and the client. The advantages can include the following:

- holistic care with multiple modalities available
- broader knowledge base within the setting
- greater scope for advertising
- ability to satisfy a wider potential patient/client community
- a wider referral base.

Wherever there are advantages, there are also disadvantages, and some of these can include:

- larger size of the setting is more impersonal
- provision of conflicting information or thoughts.

A client may present to a multidisciplinary setting with the view of having more than one modality as his/her condition changes or improves. For example a client with a chronic lumbar disc bulge may suffer an acute exacerbation and choose to have acupuncture for immediate pain relief and reduction in inflammation and then remedial massage therapy to decrease the muscular spasm and tension. The client may then follow on to physiotherapy for traction or a stretching and strengthening program. Here three modalities have been used to provide the client with the best possible outcome. The client may then decide to have remedial massage therapy at regular intervals, such as monthly, and start a Pilate’s gym class to prevent future exacerbations.

Within a rehabilitation setting there are a wide variety of clients and cases. Clients can come from a variety of sources including, medical practitioners, allied health providers, third party payers such as Workcover insurers and motor accident authority insurers, and employers. Traditional referral sources continue to exist, such as family and friend referrals and those attracted by advertising in various media such as the yellow pages and building signage. Some third party payers such as Workcover New South Wales require a remedial massage therapist to have a provider number recognised by that institution. This can be necessary for receiving a higher rate of remuneration for the service provided. If the remedial massage therapist is treating a client funded by a third party, such as a Workcover insurer, the therapist must ensure that he/she has the appropriate consent from the client prior to talking to the third party. The remedial massage therapist must also provide clear documentation of the subjective and objective histories with treatment followed by measurable post treatment improvement. It is essential that the remedial massage therapist maintain regular communication with the referral sources.

The types of injuries or conditions treated within a rehabilitation setting are quite varied and as such the type of treatment must be altered appropriately to achieve client specific outcomes or goals. Acute conditions may include strains and sprains from sports, workplace injuries or poor ergonomics. Chronic conditions may be due to repetitive strains injuries, altered posture or biomechanics due to an unresolved acute injury that has now become chronic or more specific conditions such as osteoarthritis and fibromyalgia. A variety of conditions may be more age specific for example juvenile rheumatoid arthritis. Therefore, the client base may
range from infants through to geriatrics. If the remedial massage therapist is treating a widespread age group they must have a broad knowledge of the anatomical and physiological differences between the ages.

Three case studies of clients that have been provided rehabilitation within a multidisciplinary setting are presented below. Here you will see the different ways in which remedial massage therapy has been applied to achieve the desired outcome or goal. Remedial massage therapy is not always applied to the injury directly but is often used to reduce the symptoms of compensation that occur as a sequela of pain avoidance behaviours or due to anatomical or physiological damage.

**Case Study 1**
History: a 79-year-old male who had a heart attack several years ago requiring coronary bypass surgery where the arteries were removed from the arms and legs for use in the bypass surgery. As the client was diabetic the circulation to legs post-operatively was insufficient and necrosis developed in both legs resulting in bilateral amputation with no prosthetic use. Hence, the client was wheelchair bound.

Presenting symptoms: bilateral hip and lumbar pain were reported. Phantom limb pain was also an issue. Objectively, the hip range of motion was 45 to ninety degrees flexion (fixed flexion deformity), reduced lumbar spine range of motion and lymphatic accumulation in the stumps.

Treatment: myofascial release to iliopsoas, deep tissue release to lumbar paravertebrals, quadratus lumborum, gluteals and residual hamstrings and quadriceps. Lymphatic clearing/drainage to bilateral stumps was performed. Self-stretching utilising belts to maintain and increase range of motion post-treatment.

Measurable outcomes: hip range of motion increased to zero to ninety degrees of flexion and improved lumbar range of motion. Stump circumference measurements were also reduced.

Additional modalities: Hydrotherapy with a Physiotherapist for strengthening and circulation.

**Case Study 2**
History: a 31-year-old male involved in a motor bike accident. Injuries sustained included degloving of the left leg with secondary infection and necrosis requiring debridement and grafting of the quadriceps.

Presenting symptoms: the client reported lumbar spine pain, altered sensation of the degloved leg and poor strength in the quadriceps resulting in inappropriate patella alignment and stability. Objectively, knee range of motion equalled zero to 45 degrees of knee flexion, straight leg raise equalled 45 degrees with reduced lumbar lordosis and significant deformity of the quadriceps muscles.

Treatment: deep stripping and myofascial release to the vastus lateralis to reduce the lateral tracking of the patella. Deep transverse frictions to gluteals to reduce adhesions were performed: kneading and myofascial release to the lumbar paravertebrals and quadratus lumborum. Passive and active self-stretching to the quadriceps, hamstrings, gluteals and lumbar spine were performed within treatments and as a home exercise program.

Measurable outcomes: Post-treatment knee flexion increased to ninety degrees. The straight leg raise increased to ninety degrees. The lumbar lordosis increased.

Additional Modalities: Gait re-training by the Physiotherapist.

**Case Study 3**
History: A 70-year-old male presented with left shoulder pain after serving in tennis. An ultrasound revealed a chronic tendinopathy of left supraspinatus and 10mm tear of the subscapularis. The long head of bicep was previously ruptured. The client was advised by his medical practitioner that surgery was not an option due the client’s age, related health issues and the length of time since the bicep injury.

Presenting symptoms: left shoulder abduction equalled 15 degrees with shoulder elevation and poor scapulohumeral rhythm. Over-activity of the trapezius and deltoid muscles was noted.

Treatment: myofascial release to the rotator cuff, specifically the supraspinatus; light transverse frictions to the supraspinatus tendon; deep kneading to the trapezius and deltoid muscles was performed.
Measurable outcomes: ninety degrees of abduction of the left shoulder with no impingement.

Additional modalities: Ultrasound and strengthening exercises by the Physiotherapist.

In summary, rehabilitation within a multidisciplinary setting is an exciting area for the remedial massage therapist to work in. There are many different conditions and clients to treat with goal specific outcomes and the ability to work with a variety of different health care professionals. It is essential that the remedial massage therapist is aware of when to refer to other health professionals to address issues outside the normal realms of their scope of practice.

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