

Collected Scientific Research Relating to the Use of Osteopathy with Reflex sympathetic dystrophy

Important:

1) Osteopathy involves helping people's own self-healing abilities to work better, rather than focussing primarily on particular conditions.

2) Each person is different, and osteopathy treats them differently.

Therefore people respond to osteopathic treatment in different ways. Treatments that work for one person cannot be guaranteed to work for another person in the same way. The fact that there is scientific research supporting a treatment in a group of people does not mean that it will always work in the same way (which is probably true of all research).

A number of things make research into osteopathy challenging. These include the two aspects of osteopathy mentioned above, and also the lack of major commercial interests to provide funding in expectation of financial returns. At the same time, there is an emerging body of research demonstrating the usefulness of osteopathic treatment.

More research is being done all of the time. I am not aware of any research which shows that osteopathic treatment, delivered by a qualified osteopath, is ineffective in relation to this area. If you are aware of any studies that show that, please bring them to my attention.

Please note: there is room for debate about the classifications used for these studies. Please let John Smartt know if you believe that any of these classifications are incorrect.

These studies are from peer-reviewed journals

Number
of studies:
2

Clinically and statistically significant results

Number
of studies:
2

Randomised controlled trials

Number of studies: 1

Duman I, Ozdemir A, Tan AK, Dincer K. 2009 **The efficacy of manual lymphatic drainage therapy in the management of limb edema secondary to reflex sympathetic dystrophy.** *Rheumatol Int* May;29(7):759-63 <http://www.ncbi.nlm.nih.gov/pubmed/19030864>

"The objective of this study is to investigate the efficacy of manual lymphatic drainage (MLD) therapy in edema secondary to the reflex sympathetic dystrophy (RSD). A total of 34 patients were allocated randomly into two groups. All of the patients undertook nonsteroidal anti-inflammatory drug, physical therapy and therapeutic exercise program for 3 weeks. Patients in study group undertook MLD therapy additionally. Then the patients continued 2-month maintenance period with recommended home programs. Volumetric measurements pain scores and functional measurements were assessed at baseline, after treatment and 2 months after the treatment. After treatment, improvement in edema was statistically significant in the study group but not in the control group. At follow-up, with respect to baseline, improvements were not significant in both of the groups. Between the groups, difference of the percentage improvements in edema was statistically significant with superiority of MLD group after treatment, but not significant at follow-up. In this pilot study, MLD therapy was found to be beneficial in the management of edema resulted from RSD. Although the long-term results showed tendency towards improvement, the difference was not significant."

Collins CK. 2007 **Physical therapy management of complex regional pain syndrome I in a 14-year-old patient using strain counterstrain: a case report.** *J Man Manip Ther* 15(1):25-41
<https://www.ncbi.nlm.nih.gov/pubmed/19066641>

"This report describes the examination, intervention, and outcomes for a patient with Complex Regional Pain Syndrome I (CRPS I) treated with Strain Counterstrain (SCS). The patient was diagnosed with CRPS I following a Grade II ankle sprain. Treatment consisted of SCS once per week for six months with one additional session each week in Months 4 through 6 for strengthening, endurance, and gait training. A re-examination was performed monthly. A clinically significant decrease of 2 points in overall pain as measured with a numeric pain rating scale (NPRS) occurred as of Month 2; a 2-point decrease in tenderness on 10 of 13 SCS tender points also measured with an NPRS was documented as early as Month 1. Throughout the treatment period, an increase in function was noted by way of patient report and objective tests and measures. Gait improved with regard to cadence, use of an assistive device, and weight-bearing status. Single limb stance on the involved leg increased from 0 (s) to 40 (s) over the course of treatment and ankle active range of motion as measured with a goniometer and muscle strength as measured with manual muscle tests both returned to normal values. CRPS I remains a poorly understood and difficult-to-treat chronic syndrome. By way of its proposed effects on the neuromuscular system and facilitated segments, SCS may be an additional effective treatment tool in the management of some patients diagnosed with CRPS I."