Myofascial Sports Massage

4 CE hours

Presented by
UltraSports Massage Therapy, Inc.

Florida CE Provider # 50-2081
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Instructor
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Course Objectives

The Participant will be able to:

✓ Describe the theory of Myofascial Sports Massage
✓ Demonstrate proper body mechanics for performing a Myofascial Sports Massage stroke
✓ Describe and demonstrate Myofascial Sports Massage strokes
✓ List symptoms, causes, athletes at risk and concerns for common physician-diagnosed sports-related injuries and conditions.
✓ Perform Myofascial Sports Massage routines for treating these injuries and conditions.
Properties and Function of Fascia:
- It is provided with numerous sensory nerve endings
- The fascial network supports & stabilizes muscles, tendons, ligaments & bones
- The most important properties are contractility and elasticity
- It assists in the production, control and motion of interrelated parts.
- It helps to regulate venous and lymphatic circulation
- Sudden stress on fascial membranes will often be accompanied by a burning type of pain

Causes of Fascial Thickening & Adhesions:
- Overuse reinforcement • Trauma induced scar tissue • Lack of use/movement • Dehydration

Goals:
- Improve alignment by improving function of superficial fascia, extrinsic musculature & joints.
- Improve flexibility and breathing. • Facilitate athlete’s neurosomatic awareness.
- Facilitate self-reliance by helping to prioritize athlete’s health and wellness goals.
- All techniques should improve structural balance & function – we are not seeking symmetry.

Myofascial Spreading - Method:
- Forget everything that you know about Swedish massage.
- Perform with very little lubricant to allow for the correct amount of tissue drag.
- Strokes are done slowly & deliberately, using the lunge stance (see Body Mechanics section)
- Spread small sections of tissue – 1-2 inches at a time.
- Initial angle of entry is about 45°, increasing to 60-75°.
- Once appropriate depth has been reached, more specific techniques can be used.
- Smooth after to balance affected tissues and to reduce potential for endemic response.

Balancing massage therapy services with specialized chiropractic, osteopathic or other rehabilitative modalities, along with good nutrition and proper exercise, is the foundational cornerstone in offering a treatment plan that will produce beneficial results & continued health.

All information on myofascial therapy is taken from Functional Integration, a class being developed by William E Bonney, Ph.D., LMT, webonney@gmail.com.
Body Mechanics:

1. Beginning table height should be set to approximately the level of the therapist’s patella. Adjustments can be made for therapist comfort.

2. Initial Lunge Stance:
   A. Feet about 2-3X shoulder width apart
   B. Arms at about 45 degrees to surface
   C. Front foot parallel to arms & pointing toward athlete
   D. Rear foot at about 45-60 degrees (not 90 degrees) from front foot
   E. Hips perpendicular to athlete
   F. Lumbar spine flat and inline with rear lower extremity
   G. Shoulders depressed and retracted (i.e. chest out)
   H. Elbows straight but not locked
   I. Upper extremities and chest relaxed
   J. Wrists are straight and inline with forearms

3. Falling Into The Stroke:
   A. First movement is to reduce the slack on the superficial tissues
   B. Then fall into the surface, while you allow your palms to separate
   C. Front knee bends as you transfer your weight to front foot
   D. Rest of body moves in unison

4. DO NOT:
   A. Bend at the waist
   B. Elevate shoulders
   C. Bend elbows
   D. Allow the rear heel to leave the floor
   E. “Muscle” the tissue
   F. Hyperextend the wrists
   G. Radial or ulnar deviate your wrists
   H. Forget to breathe
**Stroke Technique:**

Working from an imaginary midline, using the palm, finger pads, finger tips, knuckles, or back of fist (“5-0 stroke”), reduce the slack of the superficial tissues and then slowly allow the palms to separate. (For palmar spreading, pressure is on the thenar eminence; no pressure is on thumbs.)
Quadriceps Strain

Muscles involved: Rectus femoris, vastus medialis & vastus lateralis

Symptoms:
Sudden stabbing pain in quadriceps muscle(s). Possible deformity or discoloration and localized tenderness. In cases of mild strains, the pain may not be felt until after the sports activity has ceased.

Causes:
Violent (eccentric) contraction of the quadriceps muscle(s) when trying to decelerate. Can occur in downhill running.

Athletes at risk:
Athletes that are engaged in sports that require explosive stop-start running motions.

Concerns:
Likely to recur unless treated properly.

What to do:
- Ice
- Rest
- Massage when subacute
- Strengthening
- Kinesio Taping®

Hamstring Strain

Muscles involved: biceps femoris, semimembranosus & semitendinosus

Symptoms:
Athlete feels a slight "pull" in hamstring(s) while sprinting but is able to continue the activity. The day after the muscle may be sore, but it does not inhibit walking or slow jogging.

Causes:
A violent contraction of the hamstrings. Also happens when the hamstrings are overstretched.

Athletes at risk, Concerns & What to do:
Same as above for Quadriceps Strain.

Adductor Strain

Muscles involved: Adductor magnus, adductor longus, pectinius & gracilis

Symptoms:
Sudden stabbing pain in the groin. Inability to draw the leg inward without pain. Bruising and swelling may show up several days later. May have palpable deformity.

Causes:
A violent contraction of the adductor muscles.

Athletes at risk:
Athletes whose sport involves dynamic use of the adductor muscles, e.g., hockey and soccer players. Athletes with weak or inflexible adductors.

Concerns:
Likely to recur unless treated properly.

What to do:
Same as above for Quadriceps Strain.

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Myofascial Sports Massage

Thigh routine (10-20 minutes)

For the previous thigh strains or for tight or sore quads, hams or adductors, focus this routine on the particular issue that the athlete is experiencing.

1. Warm up quads with palmar spreading from knee to ASIS getting deeper with each pass. 4-5 repeats. You can repeat using single knuckle or fingertip spreading.

2. Stand perpendicular to athlete, medially rotate femur & knuckle spread (5-0 stroke) from anterior to posterior, across vastus lateralis and ITB from knee to greater trochanter. 2-4 reps.

3. Rotate thigh laterally, and palmar spread adductors from anterior to posterior from knee to groin. Can also do this with 5-0 spreading from opposite side of table. 3-4 reps. This can be very uncomfortable for athletes with adipose tissue. Smooth after.

4. Place foot flat on table & warm posterior thigh with friction. Pick up thigh & knuckle spread from posterior knee to ischial tuberosity. Make several passes and vary the thigh angle to hit vastus lateralis & ITB and biceps femoris.

5. Work semimembranosus, semitendinosus and medial thigh by going over leg and abducting thigh slightly. This is a good way to do the gracilis. Smooth posterior and lateral thigh.

6. Finish with palmar spreading of quads.
Shoulder Issues (Rotator cuff injuries)

Muscles addressed: Serratus anterior, latissimus dorsi, teres major, teres minor, pectoralis major, pectoralis minor, subscapularis, infraspinatus, supraspinatus, & trapezius

Symptoms:
Onset of pain is usually gradual. Pain and weakness during shoulder motion. Localized tenderness at affected muscle.

Causes:
Powerful repetitive over arm and shoulder motions. Sudden frequency, intensity or duration of the training regimen.

Concerns:
If neglected, rotator cuff injuries can deteriorate to the point where long layoffs and intense rehabilitation are necessary to correct the condition. Surgery may be necessary. Rarely do athletes who require surgery regain their preinjury form.

What to do:
- Ice
- Modify activity/motion so that it does not cause pain
- Cease the activity
- Myofascial Sports Massage
- Stretching and strengthening
- Anti-inflammatories
- Kinesio Taping ®
Shoulder Routine (15-20 minutes)

Have athlete indicate exactly what movement causes the discomfort. Assess initial bilateral shoulder ROM. Note any differences between right and left. Ask if any tightness, pinching (impingement) or discomfort of any kind. Muscle test to determine if any shoulder/arm functions cause pain. Focus on those muscles during the treatment, but don’t rule out the possibility that the pain is the result of trigger points.

1. With athlete supine, abduct and externally rotate affected arm to a comfortable position. There should be NO pain or discomfort of any kind. Shoulder should be totally flaccid.

2. Spread a minimum amount of lubricant on lateral thorax. Palmar spread from lateral edge of scapula toward the pelvis. Fingertip spread & palpate for the serratus anterior TrP.

3. With fingertips, spread the teres m/m, while applying gentle pressure to further extend the arm. Watch for supraspinatus impingement! Gently pinch the teres m/m between thumb and index finger to locate TrP’s.

4. From the best direction that maximizes tissue contact while preserving athlete modesty, palmar spread and/or fingertip spread pectoralis major. Repeat several times, progressively going deeper.
5. Support the athlete’s arm and forearm away from and in front of the chest so that the hand is about at the level of the sternum. Palpate for the origin of the pectoralis minor under the breast tissue. Have the athlete reach for the opposite wrist or elbow while holding pressure. Fingertip spread towards the coracoid process.

6. Again, supporting the arm, palpate for the subscapularis muscle. Have athlete reach across his or her body to the wall and relax (6a). This should allow for deeper penetration into the axilla. Have the athlete reach toward the ceiling and then relax (6b). Palpate for subscapularis TrP’s and try to release.

7. Place arm across body & knuckle spread from greater tubercle to scapula, working the posterior deltoid, infraspinatus & teres minor. Repeat several times while applying pressure to coax the arm more medially.
8. Return arm to athlete’s side. Abduct head and rotate slightly. Knuckle spread from anterior to posterior neck to work upper trapezius and then from occipital ridge to scapula. 3-4 reps.

9. Palpate the supraspinous fossa for the supraspinatus muscle & fingertip spread toward its origin.

10. Palmar spread the anterior & posterior arm to work the flexors and extensors.

11. Turn athlete prone and work traps, rhomboids and posterior scapula.

12. Turn athlete supine, test ROM again and stretch entire shoulder.
Neck Sprain (or tightness or soreness)

* Cervical disk or vertebral abnormalities must be ruled out prior to treatment.

Muscles involved: Scalenes, Splenius capitis & cervicis, upper trapezius, levator scapula & rhomboids

Symptoms:
Immediate pain on one side of the neck. Pain usually diminishes within thirty minutes, after which time a dull ache develops. Involved neck muscle(s) may spasm. ROM is limited, potentially to the point of holding the head in an unusual position to avoid pain.

Causes:
A single (possibly) violent impact that forces the neck into an extreme position. Sprain or discomfort may also be caused by a simple movement or by having the head and neck in a compromised position for an extended period of time, as during sleep.

Athletes at risk:
Neck sprains are most common in athletes in contact sports and in those activities with a potential for falling accidents.

What to do:
- Ice may help if inflammation is present
- Heat may provide some relief
- Myofascial Sports Massage
- Gentle stretching of involved muscles
- Kinesio Taping®
Neck Routine (10-15 minutes)

Test athlete ROM before starting to get an indication of cervical flexibility.

1. With athlete supine, spread a minimum of lubricant on anterior & lateral surfaces of neck.

2. Starting on right side of neck, with head fully rotated to left, 5-0 spread anterior to medial to posterior while gently applying pressure to R temple to more fully rotate head to left. 3-4 reps with increasing pressure. Repeat on L.

3. Cradle head, rotated to left, fingertip spread from mastoid process to clavicle to work the scalenes. 3-4 reps from different angles. Repeat on L.

4. Pick up head and 5-0 or thumb effleurage from occipital ridge to trap and beyond to work upper trap, splenius capitus/cervicus & levator. Work both sides and back of neck down spinous processes.
5. Grab right SCM between thumb and index & middle finger and milk in 3-4 places. Athlete might feel TrP refer to ear, temple or forehead. Repeat on L.

6. Fingertips under neck along occipital ridge feeling for hypertonicity. Allow posterior muscular to release.

7. Smooth all areas. Recheck cervical flexibility.