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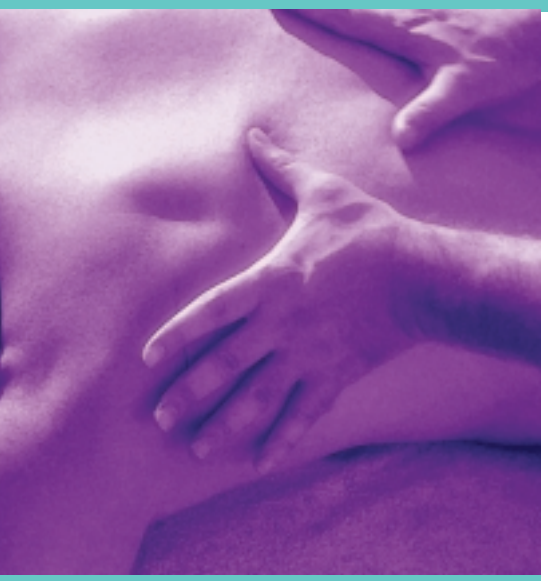

I N D E X

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Articles

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Submission of articles is welcome. Article structure does not have to conform to standard scientific literature format; however, they must be clearly written and grammatically correct. References, when used, must be numbered consecutively, in the order in which they appear. The Technical Editor reserves the write to edit and place material where appropriate, to accept or reject material, and to reject copyrighted material unless consent of the copyright holder has been obtained in writing.
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Ontario Therapist Massage Association
PROFESSIONAL HANDS YOU CAN TRUST

1304 – 2 Carlton Street
Toronto, ON M5B 1J3
Tel: 416-979-2010
Toll Free: 1-800-668-2022
Fax: 416-979-1144
www.omta.com

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NOTES from the editor

Scars can be more than skin deep

This issue of the JSTM introduces the treatment of people with scars. Scars can produce pain, limitation of movement and challenges to how we look at ourselves and think of ourselves. The treatment of scars requires extra sensitivity and skill. To touch a scar is frequently to touch a vulnerable aspect of a person. To touch it with respect and sensitivity is often healing.

The therapist's sensitivity and support is one side of the coin. The client's permeability to processing emotional content may also be a factor. Suzanne Scott performed a study in 2003 at King's College in London (Laurent 2003).

36 participants spent 20 minutes writing, for three sessions a week. One half of the group wrote about emotionally charged experiences that they had not shared with anyone before. They were asked to write in strongly emotional language. The other group was asked to write about non-emotional material such as time management, and to avoid emotional language.

During the second week of the study, all the participants received a punch biopsy which created identical wounds in their upper arm. 14 days after the puncture the participants who had been journaling about stressful events had smaller, more healed wounds than those who had been writing about mundane matters!

Those participants that had been expressing emotional experiences in strong emotional language healed better.

I once treated a client who had a subcutaneous cancer removed several months before the massage. During the treatment, she related that she had diminished feeling in the area and had really just "shut herself off" from the injury. I asked if I could touch her scar and she assented, telling me it might be good to have someone touching it. I held, kneaded and stroked it, while she silently cried. Her entire arm relaxed and her breathing deepened. After the treatment, she told me how wonderful it felt to be connected to her arm again.

Touching another human being is a gift. We can ease pain, suffering and loneliness. And all our scars can become more pliant and less constraining.

Doug Alexander

Reference

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JOURNAL Soft Tissue Manipulation

Scars of Life

By Pamela Fitch

Background

This winter, the Algonquin College Massage Therapy Program launched its first Scar Outreach Clinic. It was designed to teach students how to mobilize scars and address the common problems associated with them such as local congestion, swelling, restriction and pain. During two, seven-week rotations, a total of thirteen students treated ten clients. The clients' conditions ranged from third degree burns on both legs, a second degree burn in the intermediate stages of healing, surgical scars - particularly two breast reductions, a messy knee scar from surgery that took three years to resolve, a 20 year old quadruple bypass scar, and a case of abdominal scarring and adhesions as a result of multiple surgeries.

This supervised outreach ran as a specialized clinic in the school. Students met the clients in the waiting area, brought them to their clinic cubicles and proceeded to take detailed histories that focused on the clients' stories of their scars. The students took notes about: discomfort, degree of mobility, problems associated with the scars, and listened for cues about the clients' condition relative to the event which caused the scar. After the client had gotten onto the table, the student palpated the scar from every direction, noticing restrictions, bulges, connective tissue adherence and reduction in range of motion. Where ever possible, students stayed with the client they were first assigned so that they could track progress over the course of each week. At the end of the rotation, they were asked to write case reports on their experiences.

Finding clients was initially the biggest challenge. We briefly advertised in the student clinic in the fall term for clients who would be willing to assist the students in outreach. If a student therapist discovered a client in public clinic who had a scar, the student would invite the individual to attend the scar clinic. Posters advertising the clinic were also distributed throughout the school. In future, we expect to publicize the clinic more widely through clinics and hospitals outside the school that deal with burn patients, mastectomy and other post-surgical conditions.

Algonquin College is not the only school to offer an outreach clinic that focuses on scar resolution. Sutherland-Chan School pioneered a breast massage clinic in 2004-5 with similar and dramatic student learning outcomes. "You can't fake scar work. It's impossible for students to truly understand how to work with a scar unless they feel it under their fingers," according to Debra Curties, SC's Executive Director and supervisor of the Breast Massage Specialty Clinic. "More than half of all the women who attend this clinic are here because they have scars. Students report tremendous satisfaction when the scars become more natural looking and less adhered. The clients are also surprised at how quickly longstanding discomfort or swelling may be addressed with simple massage techniques." (Curties 2005)

Learning Outcomes

We expected that following a seven week rotation in the Scar Outreach Clinic, students would be able to achieve the following outcomes:

1. Differentiate the texture and nature of various types of scars;
2. Consider any complications associated with the client's condition;
3. Appreciate the stories, meaning and emotion associated with each scar;
4. Know how to massage and mobilize a scar;
5. Provide homecare and hydrotherapy for scars.

All of these outcomes were met as well as a few that were not considered prior to the initiation of the outreach.

At the end of the rotation, students expressed more confidence in their skills at palpating and treating swelling. They appeared better able to differentiate fascial restrictions. And they demonstrated a deeper awareness of how movement, connective tissue, lymphatic congestion and restriction inter-relate. They exhibited stronger interviewing skills and showed deeper appreciation and compassion for their clients' histories. Three students named this their favourite outreach clinic and hope to specialize in scar work when they begin their practices.

What is a Scar?

Scars are the principle way that the body knits itself together following injury or inflammation. Scars form following a wound – whether that wound has been caused by trauma, infection, surgery or burn. Wounds that are sutured and have no tissue loss heal by *primary* intention. Wounds that have loss of tissue or contamination, such as burns or large surface wounds heal by *secondary* intention and take much longer to resolve.

According to Porth (1995), wound healing is commonly divided into three phases:

Inflammatory phase – begins at the time of injury and lasts for one to two days. It prepares the wound for healing. Blood vessels constrict and initiate clotting. Then they dilate and allow plasma to leak into the injured area. It is important not to massage a wound at this stage as it is prone to re-injury, reopening and infection.

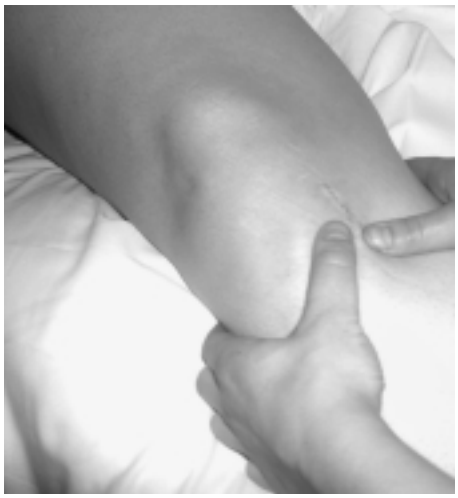
Proliferation phase – begins within two to three days of injury and may last up to three weeks. Fibroblasts synthesize and secrete collagen and produce growth factors that help to form new blood vessels. Collagen synthesis reaches a peak within five to seven days, after which gentle massage may begin. Infection control is still an issue at this stage and any massage begun in this phase must be careful so as not to disturb the fragile construction underway. The goal at this stage is to promote drainage and encourage circulation rather than challenging the scar formation.

Remodelling Phase – begins approximately three weeks after injury and may continue for up to two years, depending on the extent of the wound. Fibroblasts synthesize collagen at the same time as the collagenase enzymes are destroyed so that the "architecture" of the scar solidifies and the scar gains tensile strength. Massage therapy at this stage may address any connective tissue restrictions, swelling or stiffness within or surrounding the scar.

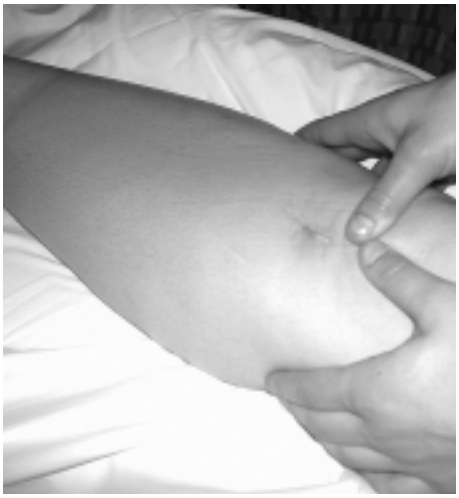
According to Porth (1995), wounds must have adequate blood flow to supply nutrients, and to remove waste, toxins, and bacteria. The resolution of a scar depends on healthy blood flow, sufficient nutrition, adequate molecular oxygen and lymphatic drainage. Pre-existing health problems or swelling can impair wound healing.

Infection, wound separation and foreign bodies are the three principle causes of delayed healing. Porth (1995) also suggests that "infection prolongs the inflammatory process, impairs the formation of granulation tissue, and inhibits proliferation of fibroblasts and the deposition of collagen fibers." Sutures are removed as soon as possible after surgery

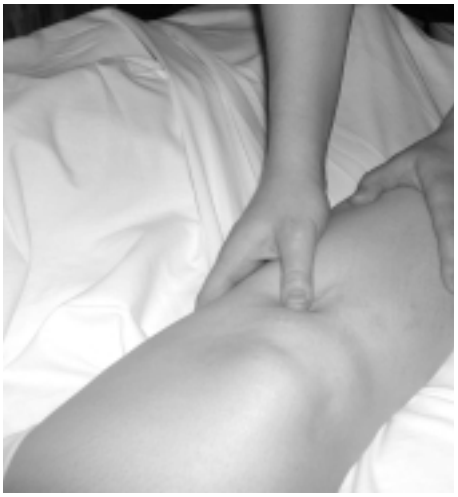
Figure 1: Three Year Old Post-Surgical Knee Scar



1A: *Palpating the surgical scar and it's tethering to underlying structures. This scar significantly affected the quality and range of motion of the client's knee.*



1B: *Assessing the mobility of the scar in a distal direction. Motion testing is required in all directions.*



1C: *Proximal stripping along the outside margin of the scar reduced it's tethering to underlying structures in a cephelad direction.*

Client Summary: *Client tore her anterior cruciate ligament during a horse back riding injury. She had a surgical repair that became infected and took three years to resolve to the point at which she was seen in the clinic. At the initial assessment she could only walk short distances, could not horse back ride or perform any of her favorite recreational activities. Her gait was altered into a swinging motion at the knee to avoid knee flexion. After six treatments the client's gait was normal, and she was able to play basketball with her son in a pain-free way.*

because they are foreign bodies and invite bacterial contamination.

Types of Scars

Hypertrophic scars are red, thick and raised but they do not develop beyond the site of injury or incision. They will improve over time. The healing time and the size of the scar may be reduced with the help of steroid application or injections, massage therapy and hydrotherapy.

Keloid scars represent an overgrowth of scar tissue that extends beyond the site of the injury. Keloids are generally red or pink and will become a dark tan over time. They occur when the body continues to produce collagen after the wound has healed and they may appear thick, nodular, ridged and itchy during formation and growth. Keloids tend to reoccur. It is unclear whether or not massage therapy can reduce a keloid although it may assist in making the client more comfortable by reducing the restrictions associated with the keloid

Contractures develop when normal elastic connective tissues are replaced with inelastic fibrous tissue. A contracture scar is a permanent tightening of skin that may affect the underlying muscles and tendons that limit mobility and possible damage or degeneration of the nerves. An example would be Dupuytren's contracture, a shortening and thickening of the palmar fascia of the hand.

Burns are wounds that are described based on how deep the damage extends and how big the area is that is affected (Mayo Clinic 2005). First degree burns are superficial and the burn does not extend to deeper layers. Second degree burns penetrate the dermis and commonly blister and swell, and they cause significant pain. These burns take anywhere from two weeks to several months to heal depending on their size or location. If a burn is only two to three inches wide and is not located over a large joint, then it may take a few weeks to heal. If the burn is located on the buttock or a large or significant joint, then it may take several months. Third degree burns involve a significant degree of penetration and charring, and may include all layers of the skin, fat, muscle and even bone. Due to the extensive tissue damage, sensation, circulation, lymphatic drainage, musculoskeletal activity, integumentary and excretory (sweating) capacities are compromised.

Complications Arising from Scars

Scars can pose a number of problems. If the scar is fibrotic or bound to underlying tissues, it may restrict movement, catch on clothing or cause irritation of the skin. There may be feeling of drag or a lack of freedom in one or more planes of movement. Clients will often demonstrate the motion that they cannot do such as fully extending the arm or side-bending to one side or another.

If swelling is present, depending on its degree, clients may feel decreased sensation or a tight, bound sensation at the point of the swelling. If there is a significant compromise in lymphatic flow, then there is a potential risk of lymphedema.

Often clients may feel uncomfortable with the appearance of the scar. They may seem shy or distressed about the scar and try to cover it. Or they may not be aware that anything can be done to change the scar and will not necessarily volunteer information about the circumstances arising from the scar.

Lymph and scar work

Lymph drainage is an important part of scar work. Often scars prohibit the easy passage of interstitial fluid into the lymphatic pathways because of the collagen matrix that forms as the wound heals. There may be swelling apparent beside a scar or between the scar and its closest bed of lymph nodes.

Bruno Chikly (2004) describes the solute fluid phase of interstitial liquid as "pre-lymphatic pathways or "tissue channels". These unorganized pathways are not con-

sidered lymphatic vessels but they help to drain and direct the substances that become lymph into the lymphatic pathways. "They are like the spontaneous waterways that water naturally carves out in a field in rainy weather. They are unorganized, unstructured pathways without an endothelial lining; as such they differ considerably from lymph vessels which are closed and highly organized units" (Chikly 2004).

According to Chikley, the collagen matrix of scars or fibrosis may cut off the pre-lymphatic pathways from their natural way into the lymphatic system, resulting in local edema surrounding the scar. As a result, Chikley suggests that it is important to realize that the lymphatic flow may not cross a scar. The therapist needs to manually "map" the flow of fluid.

When surgeries occur along skin folds or creases, the action of the joints and muscles normally result in good resolution with little swelling. Because breathing and movement are the two "engines" that speed lymphatic flow, (Uren 1999) the movement of the joints and muscles probably assist in resolving the scar with little or no swelling.

When scars are located in areas without nearby joints, as one sees with mastectomy, then the scar has less movement and there are often puckers or small pockets of swelling that accompany the scar at either end of it. Burns on broad parts of the trunk or limbs that are not close to joints may also have more local swelling and lymphatic compromise than if they were located near joints.

Lymphedema and its Implications for Massage Therapy

When considering scars of any sort, it is important to recognize that the presence of persistent swelling indicates lymphedema (Chikly 2004). Lymphedema is the term used to describe swelling that occurs as a result of compromise or obstruction in the lymph nodes. Lymphedema that happens systemically as a result of a biochemical or systemic malfunction of the lymphatic system is called primary lymphedema. Secondary lymphedema occurs as a result of a wound, surgery, burn or infection in one part of the body. The lymphatic flow stemming from the affected area is compromised and may result in lymphedema distal to the injury (Chikly 2004).

The most common reason for secondary lymphedema is a radical dissection of the axilla in combination with breast cancer surgery (Uren 1999). Traditionally, several lymph nodes are "sampled" when the cancer is removed in order to determine whether or not the cancer has matastasized to the lymph system. There are approximately 50-75 lymph nodes in the axilla. Many years ago, dozens if not all the lymph nodes were taken and women frequently lived with chronic lymphedema in the affected arm (Breast Cancer Organization, 2005)

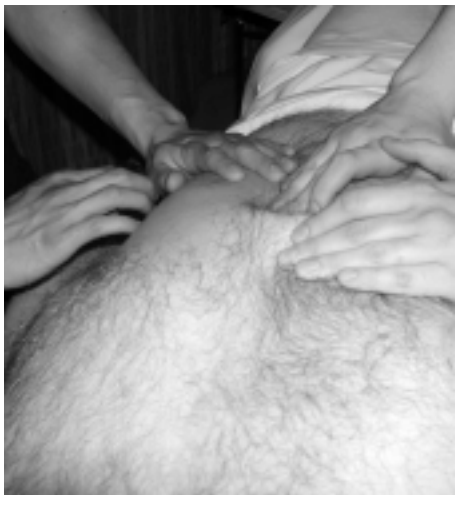
In 1993 and subsequently confirmed in a number of other studies, it was discovered that the "sentinel" node biopsy was a more effective way of confirming metastasis (Uren 1999). The sentinel node is the first lymph node that filters fluid draining away from the breast (Breast Cancer Organization, 2005). Currently, surgeons either excise the sentinel node and/or take as few lymph nodes as possible. Under these circumstances, lymphatic flow to the upper extremity is not so deeply compromised and the risks of lymphedema are somewhat reduced.

That being said, it is important to remember that scrapes, wounds, bruises and even torn cuticles may result in lymphedema (Chikly 2004) so massage therapy must be gently and carefully applied with attention given to handwashing and short smooth nails so as not to cause abrasions or infection. Pressure should be light and not result in any hyperemia. Any change in the temperature of the limb should immediately be addressed by stopping massage and applying a cold pack.

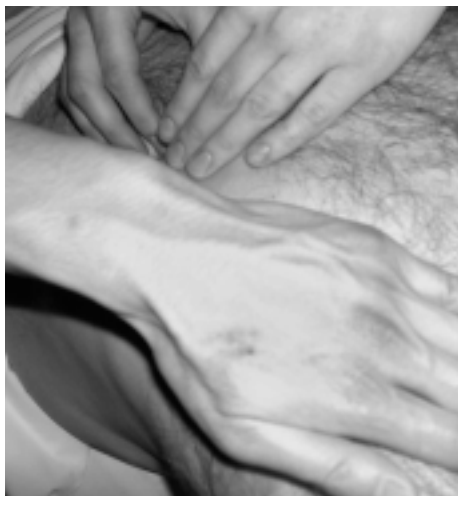
Techniques for Treating a Scar

When first palpating a scar, it is impor-

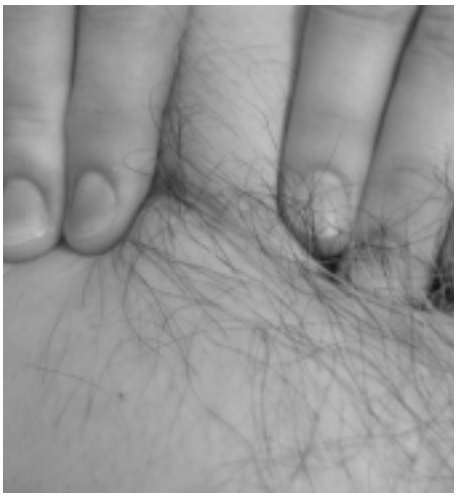
Figure 2: 20 Year Old Triple Bypass Surgery Scar



2A: *Palpating and tracing the scar along the length of the left side of the sternum. Client had a lot of congestion along the distal third of the scar in the region of the xiphoid.*



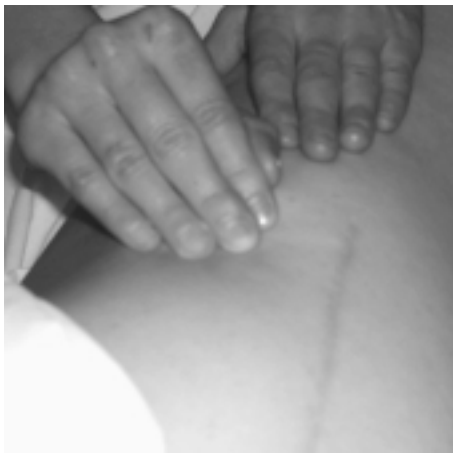
2B: *Mobilizing the myofascial tissue to the left side of the scar.*

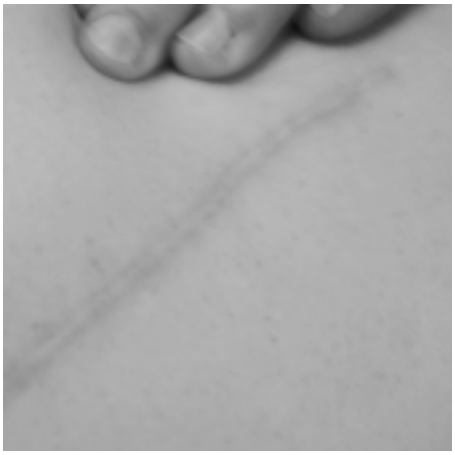


2C: *Torquing the scar tissue with s-bowing technique.*

Client Summary: *This long standing scar seemed to be a contributing factor in the client developing a significant thoracic kyphosis. This kyphosis was not resolved or changed in a noticeable way through these interventions. However, the lymphatic congestion on either side of the scar was resolved and the client had more comfort in the movements of abduction and extension in both of his shoulders.*

Figure 3: Three Year Old Hip Replacement Surgery Scar





3A: *Introducing motion into the investing layer of deep fascia anterior to the scar. (Client in left side lying with the right thigh up and the knee flexed).*

3B: *Dragging the scar anteriorly within the plane of the skin and superficial fascia.*

Client Summary: *This client had pain which prevented her from lying on her right hand side, and the scar had congestion on either side. Both the congestion and the pain were relieved over the course of seven treatments.*

tant to sense whether the scar is impeding lymphatic flow or if it is adhered to underlying structures without any associated swelling. A treatment principle that we teach in this clinic suggests that if swelling is apparent, then this should be addressed before freeing up the scar because any connective tissue release techniques may promote further swelling.

Fluid techniques should be slow, deliberate and move in the naturally palpable direction of flow surrounding the scar (Chikly 2004). Vibrations, light alternate thumb and finger kneading and short, circular lymphatic techniques in the direction of normal lymphatic flow were found in this clinic to commonly reduce swelling in and around scars in an observable way within one to two treatments.

After swelling was reduced (or if there was no observable swelling) fascial techniques were applied that challenged the scar and any associated adhesions. These manipulations included s-bowing, deeper finger and thumb kneading that torqued or changed the adhesion's directions, and skin-rolling. If swelling increased, then the therapist returned to lymphatic techniques until the congestion subsided.

Conclusions

According to clients and students, the Scar Outreach Clinic was a success. It provided a unique opportunity for students to understand the interconnectivity between fluid movement, fibrosis, restriction in movement and congestion.

In future, we hope to publicize the clinic more widely and will run it four times over the course of the next academic year. Students will be asked to write case reports on each of their clients so that we can track the successes, address concerns and more formally measure the outcomes of working with scars. We also hope to photo-document the progress of each client's scar.

Pam Fitch has been a Massage Therapist for 18 years and has contributed widely to the profession, as facilitator, writer, mentor and educator. She joined the faculty of Algonquin College in Ottawa in 2003. Pam can be reached at p.fitch@rogers.com .

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Every Scar has a Story

One of the most important considerations when working with scars is to appreciate that every scar has a story, a history and has meaning to the client. Scars should be treated with the utmost respect and compassion. How a therapist treats a person's physically-apparent scars will tell the client how the scars that are invisible are judged or perceived.

Depending on the origins, the scar may represent many different emotions or combinations of feelings. Some of these include:

- Pride e.g. – sports injury at a championship;
- Shame e.g. as a result of an assault;
- Fear e.g. – as a result of a burn, cancer surgery or other life threatening disease;
- Regret or grief e.g. - caesarean section, amputation;
- Nationality e.g. – tribal scars or initiation rites;
- Self-loathing e.g. – self injury or "cutting".

It is important for therapists to get as much information about a scar as possible before beginning treatment on it. Sometimes it may be more important for the client to tell their scar's story than for the therapist to address the scar's restrictions or congestion.

When a therapist sees a scar, it is important to ask about it. The client may have forgotten to mention a very important event or injury or it may indicate a level of trauma that was not evident from the case history. Not all scars bear receiving treatment. It may be too painful, too emotionally charged or upsetting to release a scar. A client must be ready to do this work. Not all scars are restricted. But if there is a restriction, it may have a purpose or remind the client of a life experience that is as yet unprocessed. Therapists may be surprised by what the client tells them.

Massage Therapy Treatment of 23 year old Second and Third Degree Burn Scars

By Chad Belanger

Abstract

A report on a case of second and third degree burn scars following four consecutive massage therapy treatments and the use of hot hydrotherapy. The patient presented with burns scars that covered over 90% of the posterior aspect of her legs and buttocks. She had been living with the scars for over 23 years. Massage treatments were directed toward decreasing restrictions and pockets of edema found within the matrix of scar tissue. The use of massage manipulations such as the direct and broad fascial techniques, skin rolling, petrissage, and stretching, performed immediately after a ten minute application of hot paraffin wax and a heated hydrocollator had a significant effect on increasing scar tissue mobility and pliancy, as well as increasing the client's range of motion and tactile sense within each leg. Techniques aimed at increasing lymphatic drainage within the scar, such as lymph pumping, the swelling technique, and rhythmical mobilization of the affected limb(s) showed to be effective in decreasing pockets of edema that had developed within the fissures of the scar.

Occasionally, these restrictions had made her unable to walk due to pain in her knees and lower legs.

Introduction

As part of a new outreach clinic within the massage therapy program at Algonquin College, my partner and I were introduced to a woman who had had second and third degree chemical burns that covered her hands and the majority of her lower body. She had acquired the burns during a workplace accident that occurred nearly 24 years ago.

Healing from the burns left her with erratic scar formations that restricted her range of motion due to the inelasticity of the scar tissue and adhesions that had developed into deeper tissues within her legs. Occasionally these restrictions had made her unable to walk due to pain in her knees and lower legs. The fact that this client had been wearing nylons during the accident had made her burns even more severe than had she not been wearing any nylons at all. Surgery had been needed to remove the nylon that had burned and melted into her skin; leaving scar tissue upon scar tissue. The client was seeking treatment to help decrease pain and restriction in her legs that occurred with activity, and believed that massage therapy was one way to help her toward this goal.

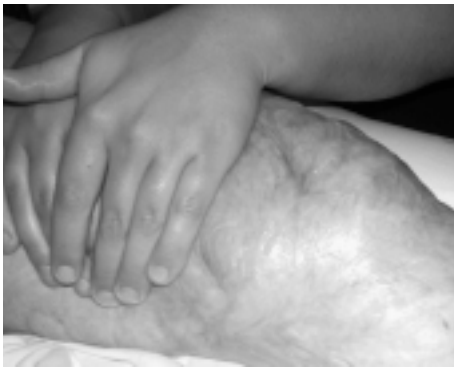

Figure 1: *Motion testing the scarring over the adductor muscles. The mobility and elasticity of the skin and superficial fascia needed to be tested and restored in all directions. Client supine with knee supported by a pillow.*

Case Report

We constructed a treatment plan that was aimed at helping to restore the client's range of motion and general comfort, by decreasing the resistance within the scar tissue itself, and decreasing the adhesions that had formed to underlying tissues in certain areas of each leg.

We noted that the most adhered and restricted areas were over the upper to mid hamstring muscles on each leg, and along the medial aspect of the lower, left leg. Her scars were very taut, thick, and red in areas over her hamstring muscles, and very deeply adhered, without any redness along the inner length of the lower leg. We also noted non-pitting edema along longitudinal lines of scar formation in the medial and posterior aspect of both thighs, and in each popliteal fossa. The client explained that she was unable to walk or play her organ for long periods of time without feeling pain in her knees and lower legs.

We treated the client for an hour long treatment, once a week, for four weeks.

Each treatment began with lymph pumping, rhythmical mobilization of the legs, and effleurage to encourage fluid drainage from congested areas within the scar tissue.

After performing these techniques for approximately 10 to 15 minutes, petrissage manipulations were then be introduced for short periods in order to reduce muscular hypertonicity in the legs posteriorly.

Petrissage was then followed with applications of hot paraffin wax over the most restricted areas of scar tissue. The paraffin wax was then covered with plastic wrap, and then covered again with a hot hydrocollator, which was wrapped in dry towels to create an optimal and safe amount of heat over the scar tissue. The applications were left on the scars for seven to ten minutes each time; causing the underlying tissues to become deeply heated, moist, and red. Due to the thermodynamic changes within the tissue of the upper thighs, the scars became much more elastic overall.

Broad and specific fascial techniques performed immediately after removing the hydrotherapy revealed that the scars could become twice as distensible as they were prior to hydrotherapy. The much deeper scar along the medial aspect of the lower left leg was not as responsive to the hydrotherapy application in comparison to the scars of the upper thighs. This particular aspect of the scar was adhered much more deeply to underlying tissues, and was very resistant to massage

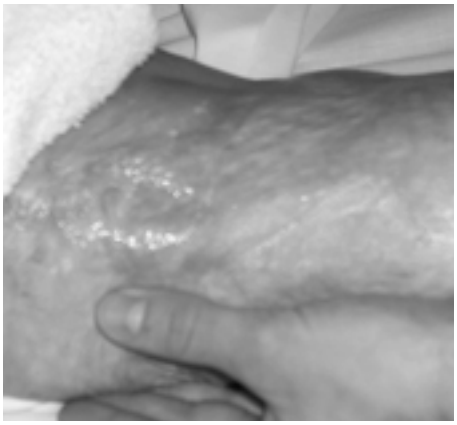

Figure 3: *Lateral mobilization of scar tissue in the back of the knee region after application of paraffin wax and hydroculator pack. Client in prone position with toweling over the thigh proximal to the knee.*

manipulation of any kind.

Direct work on the scar tissue itself was the primary focus of each treatment and constituted the majority of our treatment time with the client.

Techniques used toward the end of each treatment consisted of stretches for the hamstring, gastroc, and soleus muscles of each leg; passive range of motion of the ankles, knees, and hips, and 'picking-up' and wringing of the scar tissue.

Her scars were very taut, thick, and red in areas over her hamstring muscles, and very deeply adhered, without any redness along the inner length of the lower leg.

We noted after two consecutive treatments with the client that the pliancy of the scar tissue had changed and had much more 'give' to it than it had before treatment began. Some areas of the scar that had been very red initially looked as though they were becoming less pigmented.

The most notable indicator to the effect of the treatments came from the client's explanation of her sense of mobility and lack of restriction in her legs. During our last treatment with the client she explained that she was able to walk for nearly two hours the previous day without having any pain in her legs. She also commented on having a sense that she had more sensation in her legs (where she normally had little) to no tactile sensation at all.

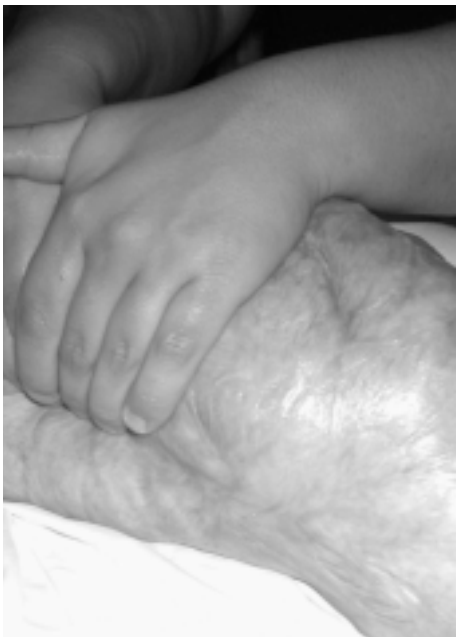

Figure 2: *Transverse mobilization of a thickened line of scarring which traveled from the proximal knee to most of the way up the inner thigh.*
This condensation of tissue was a result of nylon stockings burning into the inner thigh during the injury.

Creating less tensional force within the connective tissues that crossed the kneed joints helped to greatly reduce pain that the client experienced in her knees and lower legs during prolonged activity.

Discussion/Conclusion

In this case, massage therapy performed after a short application of deep moist heat proved to be very effective at decreasing the amount of restriction within long-standing scar tissue of a client's legs.

Creating less tensional force within the connective tissues that crossed the knee joints helped to greatly reduce pain that the client experienced in her knees and lower legs during prolonged activity.

It is believed that with less force from scar tissue pulling the knee joints into approximation that there may have been less friction, causing less pain within the joint of each knee. However, it is possible that the decrease in the client's pain could have been associated with supplements that she had used for arthritic flare-ups.

The burn scars of the upper, posterior thighs were significantly more elastic not just during treatments, but also during the client's activities between treatments; giving her more mobility and range of motion. The client also expressed that she had more sensation in her legs as a result of treatment, leading us to believe that underlying neurological tissues benefited from the decrease in restriction as well.

Massage therapy may have brought the client to have more of an awareness of her sense of the scar; therefore giving her a sense of more sensation in her legs. Apart from the increase in sensation, the findings noted were very much in line with the goals and anticipated outcomes of the treatment plan.

Chad Belanger is a recent graduate of the Massage Therapy program at Algonquin College. He is looking forward to pursuing a career in palliative and supportive care.

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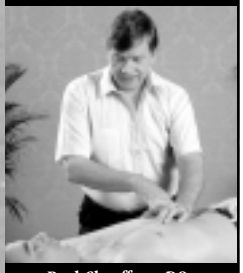
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A Personal Experience of Massage Therapy for Scarring

By Jennifer Dynes

Introduction

I was fortunate enough to participate in the first scar outreach program at Algonquin College. Through my seven week placement I had the opportunity to work on both chronic burn scars and surgical scars from a variety of different procedures. At the end of each treatment I was left with this great feeling of satisfaction. The work was not aggressive and done in a slow manner with frequently amazing results. After only one treatment, clients often saw a decrease in swelling, increased range of motion, change in color and a new outlook on their scar.

While working on a mastectomy scar, I checked in with my client to see how she was doing and her response was "It feels good! It's been a long time since I have been touched there". At the time I knew that it was a powerful statement but would not realize, until my own experience, how much that treatment affected my client.

My Medical History

I'm a 27 year old female with severe, chronic hydronephrosis. Over the past six years, I have undergone three major surgeries to correct my right kidney problem. Two of these surgeries where conducted 11 months apart. The three surgeries were conducted to reduce an obstruction of the ureterpelvic junction of the kidney. As a result of the obstruction the pelvicalyceal system of the kidney appears severely dilated and static with multiple stones present. The kidney however is asymtomatic. The pain that I experience is from chronic recurrent urinary tract infections as a result of the obstruction. At the present time the function of the kidney is within normal limits and the only concern is structural.

My Experience

It is hard to put into words how I felt leaving the clinic after my first treatment. I felt that I had opened up; that I was able to stand up straight and walk with an extra spring in my step. As I walked to my car, I had a sense of ownership of my body and that I was, in some way, "new again".

It's easy to throw these descriptive words around, but for the first time I had a sense that I was beginning to conquer my kidney problems. During the recoveries of the past three surgeries I never once thought, or had an urge, to fight this problem. It was always a condition that needed to be treated in order to maintain my health, not something that needed to go into battle with.

At the end of my last treatment I felt that my kidney problem was no longer my identity. I never realized that it had such a strong hold on me. I knew I felt frustrated due to the time commitments of the surgeries and the time that it affected me in my life, but I never would have imagined what it actually stole from me. It took away my living-in-the-moment way of life. Thanks to the treatments I have taken this back.

During the fourth week of the outreach I came down with a kidney infection, so I was only able to receive three treatments.

Conclusion

Many people may throw around the phrase "power of touch", but today, thanks to my Massage Therapist I experienced the meaning behind it. After only a few treatments I feel like a new person. I may be left with the physical scar, but I've taken back everything that I wasn't even aware that I lost.

Jennifer Dynes is a recent graduate of the Algonquin College Massage Therapy Program. She is presently working with a company in Barrie, Vitality for Life, where she hopes to continue her work and increase her knowledge on the benefits of massage on various types of scar tissue adhesions.

Abdominal Surgery Scar Self Massage

Recommended massage time is 5-15 minutes per day. Use the pads of your fingertips and stick to the skin. Do not slide across the skin. When the scab has fallen off and there is no seepage you can directly massage on the scar.

1. **Circles:** Make small circles in both directions all over the abdomen one to two fingers deep. (you can do this on or close to the scar when scab falls off).

2. **Bowel Stimulation:** Massage in circles with counter-clockwise motion starting at the right hip, going up to ribs, across abdomen, and down to left hip. This helps with the correct movement of gas.

3. **Desensitization:** Use a rough, wet, washcloth to rub across the scar in all directions. This will help you feel more at ease touching the scar. It will also make it less sensitive to waistbands and clothing touching it.

4. **Push and Pull:** Place two fingers directly on the scar and move it slowly towards you head. When the skin stops moving, hold the scar in that position for 1-2 minutes. (There will be a pulling sensation, but there should not be sharp pain.) Then move the scar down, right, and left using the same procedure as above. Spend more time on directions that are more limited than others.

5. **Skin Rolling:** Pinch the skin on either side of the scar, lifting the skin up. Start at either end and move forward and backward, rolling and raising the skin as you move. A free scar bulges upward, a stuck scar will dimple. Try doing these movements two to four weeks after surgery.

6. **Plucking:** Put your index finger on one side and thumb on the other side of the scar. Try and lift scar up, separating it from the underlying tissues. If the skin slips out of your hands, you may not be ready for this stage. Try these three to six movements weeks after your surgery.

This client handout is provided courtesy of Megan Houreis and the U.S. Department of Health and Human Services, Indian Health Service at www.ihs.gov>http://www.ihs.gov

Massage Therapy Treatment of a Four Month Old, Second Degree Burn

By Rosita Tsamis

This is a case report of a client suffering from a four month old, second degree burn. The client was experiencing pain in the right lower quadrant of her back, as well a stiff achy pain on her left back and gluteal region. This report shows how massage interventions helped relieve most of her symptoms over the course of five treatments.

Introduction

The following case refers to a client who suffered a burn trauma four months prior to her visit and was experiencing symptoms arising from a healing second-degree burn. The client's bandage had just been removed. Massage interventions helped relieve most of her symptoms and decrease fascial restrictions relative to her scar.

Initially, the scar was a bright redish-purple colour, with minimal blistering, visible congestion and was restricted when moving towards the edges of the scar. She had been experiencing a lot of "itchiness" and had been treating her burn with daily applications of vitamin E cream. Her lumbar range of motion was limited in flexion, rotation to the right and left lateral flexion with pain in all directions.

She was limited to wearing jogging pants, because all other clothing would rub against her scar and cause irritation and discomfort. Her short term goal was to decrease discomfort, and increase lumbar mobility. Her long term goal was to return to work as a bus driver where she is expected to work 12 hour shifts.

At the initiation of the treatment series, her pain was at a 6/10 on a pain scale where 1 is described as very minimal (or no pain) and 10 is the strongest pain imaginable. It was decided that we would record her pain prior to each treatment as a method of keeping track of her progress.

Interventions

Lymphatic techniques played an important role in the series of treatments. The client seemed to respond the most to sacral pumping and a milking technique encouraging fluid to drain towards the inguinal nodes to decrease inflammation. This drainage process was performed for roughly 25 minutes and there was a significant decrease in the congestion even after the first treatment. During the first treatment, the client was not able to tolerate fascial mobilization and the post-drainage phase of the treatment was limited to effleurage, light kneading and various percussive techniques.

After the third treatment we started to treat compensatory structures due to her four months of bed rest.

The second and third treatment proceeded as described above, but the client was now able to tolerate some fascial mobilization. This showed great results as the scar became more mobile and seemed to only be restricted proximally where the bandage had been taped for four months. The colouring improved dramatically; it was now a light pinkish colour resembling a bruise, the blistering has decreased, and the client's pain decreased to about 3/10.

Lympahatic techniques played an important role in the series of treatments.

After the third treatment we started to treat compensating structures due to her four months of bed rest. Hypertonicity and trigger points were discovered in her left quadratus lumborum, erector spinae, gluteus, hamstring and gastrocnemius muscles, as well as her right upper trapezius, rhomboid and scalene muscles. These muscles were also treated with sustained passive stretching, and the client was taught stretches for remedial exercises.

At this point, the client was thrilled because she was able to wear jeans for the first time in over five months, had very little low back discomfort, the itchiness has subsided and was able to forward flex her lumbar spine pain-free, and her pain level was down to 1/10.

The client missed a treatment because she fell ill. Upon returning, her pain had increased to 3/10 and some of the congestion had returned. This was also the week that she was scheduled to return to work, but had to postpone the date another two

Intensity of pain throughout TX plan

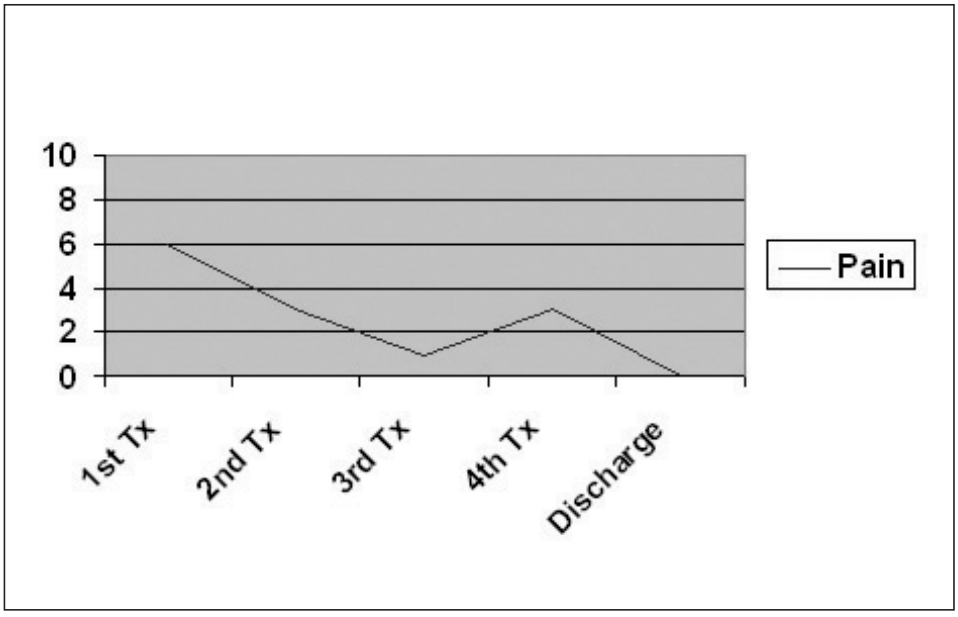

Figure 1 *Depicts the intensity of the client's pain over the course of five weeks. The pain was recorded prior to each treatment and again after the final treatment/time of discharge.*

weeks because she was still not able to tolerate prolonged sitting.

On the final treatment, the client's pain was recorded at a 0/10 and she had full range of motion of her lumbar spine with minimal pain in left lateral flexion. The scar was healing well: the size of the scar decreased and the skin was beginning to look like her normal healthy skin. There was still some restriction proximally, with a little darker colouration in this area. However, the client was to return to work that week and appeared fully capable of doing so, and was therefore discharged.

Discussion

This was an exceptional client as she was really dedicated to her recovery, and as a result did her remedial exercises exactly as prescribed. She also started seeing a personal trainer and exercised at least three times a week in order to strengthen muscles that were weakened due to her period of bed rest.

Her exercise routine combined with her regular massage treatments helped her recover quickly and achieve her long-term goal of returning to work shortly after the set date. By the last treatment, the scar had increased fascial mobility, decreased inflammation, no blistering, no itching, and the colour was beginning to look like her normal skin in many sections of the scar.

Conclusion

This study shows how massage therapy interventions helped relieve most of the pain and symptoms relative to a specific case of a four month old second degree burn. The client responded well to the treatments and regained a lot of her lumbar spine range of motion in every vector but primarily in forward flexion and right rotation. Most importantly, she was able to resume her activities of daily living without pain. Her pain decreased gradually throughout the treatment plan and was at a 0/10 at the time of discharge.

Rosita Tsamis is a recent graduate of Algonquin College. She has a particular interest in working with individuals suffering from restrictive scars either surgically related, or due to burn trauma.

References

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Adverse Effects from Breast Reduction Surgery May be Alleviated by Massage Therapy

By Rachelle Lauzon

Introduction

Every scar tells a story, and I have had the privilege of hearing many incredible stories throughout the past few months. As a recent graduate of Algonquin College, I took part in the massage therapy program's first scar outreach. My time spent at the clinic was powerful and uplifting and made me aware of the need to promote scar work in our field. Although I was exposed to several types of scars, including burns, abdominal surgery scars and mastectomy scars, I spent the majority of the experience treating a client who had undergone a breast reduction several years prior.

The outreach has opened my eyes to the benefits that massage can have on scars, and since that time I have had the opportunity to treat two more women with breast reductions. These women have given me permission to share their scar stories and hopefully, others can learn from these tales and benefit from them as I have.

Old Scars

My first client had her breast reduction at the age of seventeen. Her breasts had developed quickly and she was uncomfortable with her appearance. She was also having back and neck pain from the extra weight her breasts created. That was over three years before she came to see me in the clinic.

When I first saw her scarring, I was quite surprised. She had a large amount of discoloration in her scars, several adhered and puckered areas and several sections of the scars on her right breast had stretched. There was also sensory loss in her left nipple and areola and the same nipple was inverted. Along with all of her post-surgery complaints, she was having regular mastalgia or breast pain due to congestion.

Our first treatment began with a thorough assessment of both breasts and an informative talk about self-examination and proper bra fitting. Many women aren't aware of how much the wrong bra can affect the amount of pain and congestion they are experiencing, so it's important to advise your client to go get a fitting done (the interested reader can go to Shapings.com for more information on bra fitting).

After the initial visit, we decided on a full treatment plan and the plan included a number of key techniques that would eventually lead to excellent results. Among the techniques were superficial fluid techniques (Andrade & Clifford 2001) , well breast massage (Curties 1999), direct and indirect fascial techniques (Andrade & Clifford 2001) on the scar and figure of eight wraps (Curties 1999), to ease pain and congestion.

After the first treatment there was a noticeable change in the shape and fullness of her breasts and the client was experiencing less pain and discomfort.

After the first treatment there was a noticeable change in the shape and fullness of her breasts and the client was experiencing less pain and discomfort. I sent her home with self care that consisted of daily self-massage (Curties 1999) and figure of eight wraps before bed (Curties 1999) (see Figures 1 and 2). The client continued these self-care exercises throughout the treatment plan, which I believe added tremendously to her results.

After the completion of the treatment plan of seven hourly visits, all of the scarring was faded and close to neutral, there was no mastalgia present, and the left nipple had released somewhat to decrease some of the inversion that was occurring prior to treatment. Most importantly, the client repeatedly expressed gratitude because she was once again self-confident about the appearance of her breasts. According to the client, the scar treatments "improved the look of the scars, helped me become more comfortable with the look of the scars, improved my self-esteem, and made me feel better because I wasn't sore anymore".

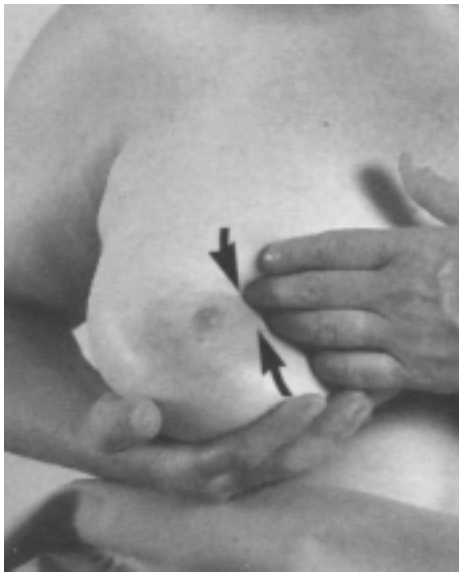

Figure 1: *Breast Self Massage*
Clients can learn to massage their own breasts. This can be an important form of self care. The reader is encouraged to consult Debra Curties' text for further information.
Image from Curties D: Breast Massage, page 166.

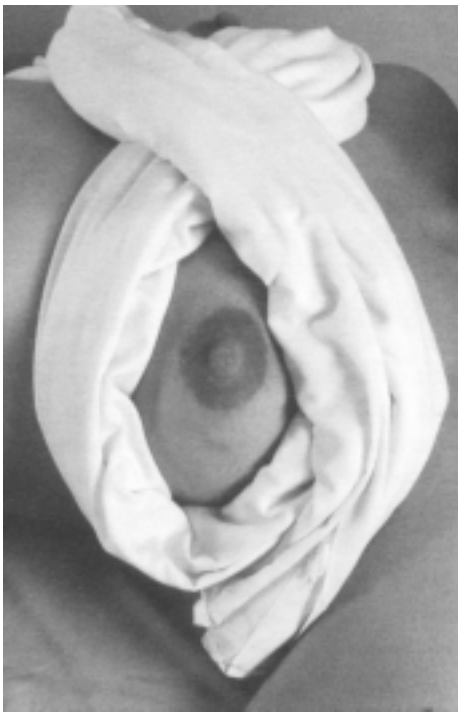

Figure 2: *Figure of 8 Breast Wrap for Congestion*
A twin sheet is soaked in water as cold as the client can stand. It is wrung out and wrapped in a figure of 8 around the breasts. The wrap is removed, or replaced, when its temperature becomes indifferent.
This is an excellent form of self care for breasts undergoing changes from pregnancy as well as from post-surgical scarring and associated swelling.
The sheet can be also used hot as a preparation for scar work, or as a contrast modality.
Protocol and image from Curties D: Breast Massage, page 169 with permission.

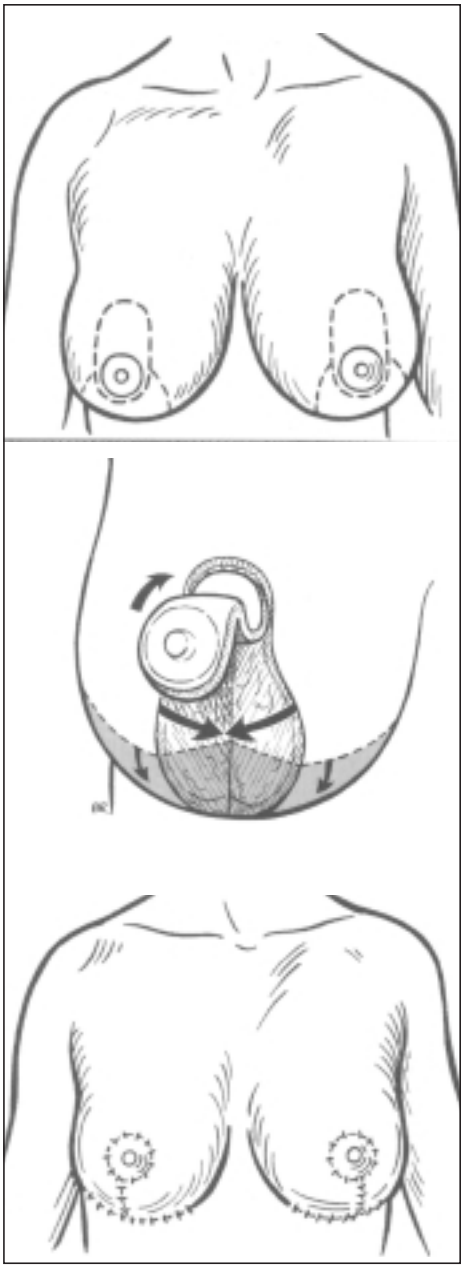

Figure 3: *The Wise Keyhole Procedure*
This common breast reduction procedure is named after its originator, Dr. Robert Wise. It leaves a characteristic keyhole type of scarring. Nipple sensation and erectility are often affected as well as the woman's ability to breastfeed.
Images courtesy of Curties D: Breast Massage, 1999, Page 178.

Insider Tip:

Take a mirror into the treatment room and have your client look at their breasts before and after every treatment. This exercise helps the client become more in touch with her breasts and allows her to see any changes that have taken place.

Here's some food for thought.

Keep in mind that the scars you can see on the skin's surface are, in most cases, only the tip of the iceberg. Beneath a superficial scar are often layers of internal scarring that cause additional pain, as well as decreased range of motion for the client. As with all other massage techniques, the principle of superficial-deep-superficial rings, true for scar treatments. It is usually necessary to mobilize the external scar before you can begin work on the deeper scar tissue. In some circumstances an external scar may look and feel healthy, but there is still a need to explore underneath and around the scar for invisible scars that may lie internally and be the root of the client's complaints.

These have proven to be significant changes for the client.

New Scars

One of the clients that I treated (after the scar clinic) came to me completely by chance. She actually came into the regular clinic at Algonquin for a relaxation massage and ended up paired with me. We began our visit with the typical client interview. When I asked her what her main complaint was, she said that she was having some trouble with her neck and back.

I had taken note of her previous visits and had noticed that she was complaining of excess weight and large breasts, so I mentioned the fact that these factors could influence her neck and back pain. As soon

When a bra fits properly the...

- breasts fill, but do not bulge out of the cups
- underwire or bottom support holds the breats, but doesn't ride up or cut in
- back hooks are level with the front of the bra, and don't ride up
- whole bra supports the weight of the breast, not just the straps
- bra stays comfortably in place when you fully flex and extend

... and there are no red lines underneath the breasts at the end of the day.

Information from Pamela Fitch and http://www.shapings.com

as I began the conversation, she confided in me that she had recently had a breast reduction and hadn't said anything because she was embarrassed. In fact, she had only completed her surgery six weeks earlier!

as my first breast reduction client, which is often known as a procedure called the Wise Keyhole (see Figure 3). It resembles an upside-down "T", and is a fairly large scar (Curties 1999, Ersek 1993).

Some of the complaints that the client had included congestion accompanied by mastalgia, puckering of the scar's corners that were trapping pockets of edema, and several areas of matted, adhered scars. There was one especially large and matted section of scarring that was located just below the left nipple where the scar had been joined together and presented as a large "hole" after surgery.

Over the course of the treatment there was a significant change in the mobility of the scars. I felt less turgor or pressure in each breast after it was treated. As well each breast was less prominent in the supine posture post-treatment. This suggests that circulation and drainage of the breasts was improved.

This was an important lesson for me; to never be afraid to ask a client lots of questions because you never know what answers you might get. After her confession, I mentioned to her that there were treatment options for her recent surgery and although it wasn't the purpose of her visit, she might want to consider treatment in the future. To my surprise she was so excited to hear that something could help that she decided to change the focus of her treatment and only have her breasts and scars worked on. It was a great hour for me because I had the chance to work on fairly new scars and use my scar clinic skills again.

This client had the same type of scarring

I chose not to use any hydrotherapy during the treatment due to the fact that the client had no sensation in either breast. Clients with these surgeries often regain sensation over roughly a year (Curties 1999). The entire treatment was very light and cautious, but I still used many of the techniques that I had used with my client from the scar clinic. Superficial fluid techniques, well-breast massage, and light fascial techniques all proved effective in reducing the client's symptoms.

Over the course of the treatment there was a significant change in the mobility of the scars. I felt less turgor or pressure in each breast after it was treated. As well each breast was less prominent in the supine posture post-treatment. This suggests that circulation and drainage of the breasts was improved.

After her treatment that day, my client left ecstatic that there was something that could help her and expressed many times that she wished everyone could know about this type of treatment. She couldn't believe that just one massage session had produced results. Unfortunately I have only seen this client once, but I hope to see her again so we can continue the therapeutic process.

Herein lies my passion for this type of massage treatment. As a therapist scar work takes such a small amount of effort, but it can benefit the client in a multitude of ways.

Conclusion

I believe that as the new generation of Massage Therapists, it is our duty to inform each other and our clients that these treatment options exist. There is a general lack of awareness and research to support the results that we are seeing in treatment rooms all the time. These two cases that I have described are a small sample of the success that our scar clinic has experienced since its opening. I hope to see this enthusiasm spread in the next few years to clinics everywhere.

The next time you are with a client and you hear the phrase "I have this scar…" remember these tales and ask about it because every scar tells a story and you might just be able to write the happy ending.

Rachelle Lauzon is a recent graduate of the Algonquin College Massage Therapy program. She is happy to finally join such a rewarding and fulfilling profession. She hopes to be the first Massage Therapist to open a massage clinic specializing in the treatment of scars in the Ottawa area.

References

Bra fitting is described with images at: http://www.shapings.com/bra_fitting.html

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