



Manual Therapy's Utility in the Treatment of Head/Neck Cancer-Related Trismus — GUEST BLOG POST

By [Walt Fritz, PT](#) / April 12, 2022

Manual therapy (MT) has been my chosen intervention for decades.

This preference began with perceptions of MT having the ability to select a specific tissue for intervention, specifically connective tissue (fascia). With such a belief, I worked to help many with a range of functional problems. However, as I moved away from my initial myofascial release (MFR) training and learned models of MT from other perspectives, my thoughts on single tissue explanations for both causation and remediation evolved.

While some of these models substituted another tissue-based problem and solution, mirroring the MFR approach I'd learned initially, others broadened the explanation of how MT influenced dysfunction. These explanations included systems-based approach narratives from the neurological and behavioral sciences and became the focus of my advancement as a clinician (Bialosky et al, 2018; Geri et al, 2019; Kolb et al, 2020).

Initially, I stuck with the term MFR to describe my work, partly due to a lack of a better description and part of which was selfish. MFR was a popular term and often attracted clinicians (physical and massage therapists) to my continuing education seminars.

When, as an MT educator, I was invited into the world of the SLP, I began seeing the need for a more balanced and evidence-informed approach, and the term MFR needed to evolve. Manual therapy was my choice. While I recognize that I left behind a brand recognized by more clinicians, intellectual honesty required I move on.

Manual therapy encompasses massage, myofascial release, manual lymphatic drainage (MDL), manual circumlaryngeal treatment, and other named models that have been regularly included in the SLP literature since at least 1990 (Aronson, 1990). However, the mention of MT as a successful intervention strategy has been primarily seen in the dysphonia realm; other areas have been subject to only anecdotal reports with a paucity of studies showing efficacy with HN cancer-related dysphagia (Krisciunas et al, 2015; Krisciunas et al, 2019) and none for trismus (Chee et al, 2021).

Last month, the paper *Manual Therapy for Patients With Radiation-Associated Trismus After Head and Neck Cancer* was published by McMillan et al, at MD Anderson Cancer Center, which looked at the application of MT with 46 HN cancer survivors with a mean of 6.6 years post-radiation and all with trismus. Findings report improvement in mouth opening of 4.1 mm following a single MT session and 6.4 mm following an average of 6 MT sessions. Treatment consisted of intraoral soft-tissue treatment, mandibular joint mobilization (passive, active-assistive, and active stretching, MDL, MFR, massage, and strengthening, all of which would be considered within the scope of practice of SLPs



who have been trained in the work. The study included other factors examined and determined, but overall, the conclusions stated:

“Conclusions and Relevance. The findings of this case series study suggest that MT improved MIO with a medium to large effect size in survivors of HNC with radiation-associated trismus. The results suggest that the largest increase in oral opening was achieved after the initial treatment and although gains were more modest, oral opening continued to improve with serial treatment.

Covariates were not associated with MT response, suggesting that patients with clinical features often considered treatment refractory (eg, advanced disease, multiple lines of oncology treatment, ≥ 5 years post-treatment) may benefit from treatment with MT. Manual therapy may be a beneficial frontline or adjuvant treatment when combined with traditional stretching therapy. A clinically meaningful increase in oral opening has the potential to improve swallow function, speech, pain, and quality of life.” (McMillan et al, 2022)

The study covers the intervention specifics of the utilized approach in a similar fashion as similar papers within the general MT field. The details typically range from highly detailed ones, which may include the protocol used (though not necessary), to vague references to approaches that leave the reader wanting more. Though not explicitly worded as such, what was apparent from reading McMillan’s paper is that there was latitude allowed for both patient-specific issues and preferences as well as for clinician preferences.

While some may see this as a detriment to evidence-based practice, such an approach is better in keeping with principles of shared decision-making (Bialosky et al, 2021; Lunghi et al, 2019; Maxwell et al, 2022).

With such studies now available, SLPs can feel validated in reaching for MT as a part of a larger intervention strategy.

Of particular interest to me was the finding that the greatest gains tended to occur with the first MT session, though additional smaller gains were noted through subsequent sessions.

Though not a part of the education and training of many SLPs, through direct continuing education training and the secondary onsite sharing of educational resources from those trained, the pool of clinicians willing to broaden into the inclusion of MT should allow MT to become commonplace in the treatment of trismus and related problems.

Walt Fritz, PT

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www.waltfritz.com

Walt Fritz, is a physical therapist in the Rochester, NY area who has been using manual therapy as a primary intervention since 1992.

He teaches his [Foundations in Manual Therapy: Voice and Swallowing Disorders](#) seminars to SLPs for ASHA credit, and other health professionals across the globe. He now has an online forum for CEUs.



Learn more at www.waltfritz.com. Readers can utilize “NiceSpeechLady” as the discount code for 10% off of the course upon checkout.

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