

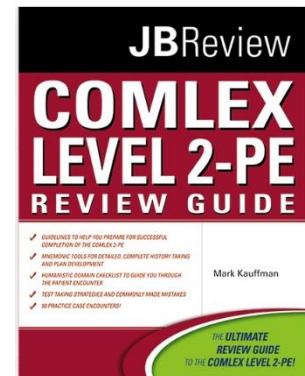


AOCPMR | American Osteopathic College  
of Physical Medicine & Rehabilitation

## OMT Basics for PE

This is a quick reference guide for the panicked brain. If you would like more comprehensive guidance, please refer to a COMLEX PE Guide such as the latest edition of Kauffman's COMLEX Level 2-PE Review Guide. There are videos for the PE on OnlineMedEd as well.

This page is derived from a combination of PE book guidelines and medical school curriculum. Your school may have taught a variation not shown; don't fret if your school format is not a 100% match – so long as all categories of information are present. Please stick with what you know and are comfortable with in terms of documentation, describing OMT, etc.



### 14 minutes for encounter

- 5-7 minutes history taking
- 4-5 minutes physical exam
- 2-4 minutes OMT
- 1 min wrap-up

### Before you begin OMT:

1. **Rule out** contraindications for OMT: via Ottawa rules and special tests (i.e. empty can), disease or injury precautions, etc.
2. 1-2 sentences, **what is OMT?**
  - a. “Osteopaths believe that structure and function are interrelated. I can adjust the underlying structure so that your body will better be able to heal and restore function.”
3. Life lesson: Must **ask** for **consent**.
  - a. “**Would you be comfortable** with that?”
4. **NO HVLA!** No thrusting techniques, including articular techniques that end with a thrust.
5. Stay away from sensitive areas. If a bathing suit covers it, don't touch it.

This section is a **sample only** referring to the OMT portions, not a complete note, **variations are acceptable**, but should include:

1. CC
2. objective physical exam
3. at least 3 DDX
4. current conditions as part of assessment
5. Plan & follow-up.

## Documenting OMT:

Subjective:

CC: "shoulder pain"

Objective:

MSK: decreased abduction of L shoulder; non-tender to palpation

Neuro: No motor deficits UE C4-T1, sensation to light touch grossly intact.

OSE (Osteopathic screening evaluation): Thoracics – T9 FRS R, hypertonic. UE – Left distal clavicle superior to right.

Assessment:

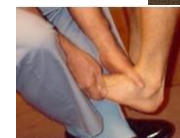
1. Shoulder pain
  - a) Upper Extremity Somatic Dysfunction
  - b) Thoracic paraspinal hypertonicity
  - c) Thoracic outlet syndrome
  - d) Rotator cuff tear
2. Somatic dysfunction on thoracics, paraspinal hypertonicity
3. Co-morbidities (HTN, COPD, any known dx)

Plan: Shoulder pain treated with OMT. Patient tolerated well. Range of motion improved. If pain returns within 24 hours consider MRI of neck and shoulder to rule out thoracic outlet syndrome and rotator cuff tear. **Patient to follow-up in 1-2 weeks for re-evaluation.**

**If your mind goes blank, use muscle energy.**  
**Put something, *literally any body part* (on daytime TV), into its restriction and have patient move away from that.**

### Examples so simple they'll blow your mind:

- **Hip pain:** Externally rotated at hips (feet & knees point outwards when supine), roll thigh towards midline into Internal Rotation and ask patient to rotate thigh so that their knee points towards you.
- **Referred knee pain:** Feet that prefer plantar flexion, put into dorsiflexion barrier.



- **Arm pain:** Wrists that prefer extension, place into flexion barrier.



## Back Pain is *very* common

**Screen spine.** Find Thoracic or Lumbar Vertebra to target. Use muscle energy.

- Ex: position patient into F, SB L, Rot L.
  - Localize to chosen level. Hold patient in that position.
  - Tell them to gently meet your pressure and “try to straighten up.”
  - Little movements if near head and shoulders! T1-T4 use the neck!

### **Vertically challenged? Tiny-hand syndrome?**

If you answered yes, **Psoas** ME is also an easy option for treating lower back pain. Mention **aloud** that the muscle runs along the lower spine, connects to the front of their body, and often causes lower back pain. *Otherwise why are you touching their leg and not their back?*

#### **Steps for Simple Psoas-Low Back Pain Treatment**

- Hold patient’s bent leg towards chest until you meet resistance, if straight leg lifts off table, their psoas is tight (modified Thomas test).
- The straight leg is the side of dysfunction. Gently press straight leg towards table to barrier.
- Ask patient to lift straight leg towards the ceiling.
- New barrier is reached via pressing straight leg closer to table and/or stretching bent knee closer to patient’s chest.



## Abdominal cases – extra minute? Add OMT.

- Palpate for tissue restriction along the ribs and lateral aspects of rectus abdominis muscles (landmarks for ascending and descending colon).
- Use myofascial release: **gentle compression and traction**.



Documentation Suggestions for Soft Tissue

**Objective OSE:** abdominal fascia restriction.

**Assessment:** Abdominal pain/diarrhea/constipation, etc.

Fascial dysfunction of abdomen... *+comorbidities*

**Plan:** Patient consented to OMT. Abdominal restriction treated with myofascial release.

Patient tolerated well. Dysfunction resolved. Decreased pain/increased bowel sounds if noted.

Patient to follow-up in 5-7 days if pain persists.

## 30 second cervical treatment: HA, Neck Pain

1. With patient sitting up, feel their neck, find a restricted vertebra.
2. Alter head position until the restriction lessens under your finger.
3. Whichever position their head is in for #2 = diagnosis.
4. Add gentle compression and move through an arc to the opposite position = Still technique.



## Sinus pain? Don't lose easy points! Treat with effleurage.

Bonus points if you open the thoracic outlet or treat first rib beforehand.



How do I document that?

**Subjective:** "pressure in face"

**Objective:** Bogginess over bilateral maxillary sinuses.

**Assessment:** 1. Face pressure a. Lymphatic congestion of head and neck b. Sinusitis c. Rhinitis... see pg 2.

**Plan:** Patient consented to OMT. Lymphatic congestion treated with effleurage. Patient tolerated well, stating decreased pain on palpation with improvement of symptoms. Decreased bogginess noted. Patient to follow-up if condition worsens or persists beyond 14 days.

## 1 technique for 5 complaints!

A **first rib** technique may be worth learning as it covers: **headache, neck pain, shoulder pain, arm pain, and rib dysfunctions.**

This technique may be performed sitting or supine as shown in this variation:  
[https://www.youtube.com/watch?v=y\\_bh0xumcZQ](https://www.youtube.com/watch?v=y_bh0xumcZQ)



1. Screen first rib. Place your hands over the patient's shoulders with your fingers placed in the supraclavicular space.

2. Physician's ipsilateral hand (to side of dysfunction) grasps the elbow on the side of the inhaled 1st rib and raises it above the shoulder (vectored toward the 1st rib). The other hand may be placed upon either shoulder (ipsi or contralateral).

3. Compress from elbow towards 1st rib swing the arm through an arc.

4. Decompress and reassess.

5. If painful/restricted side is a depressed rib, name it that, and move arm in a backstroke motion rather than forward stroke.

# Good Luck!