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1. Introduction
One of the principles in osteopathic medicine is optimisation of the circulation in the region of complaint. The heart obviously plays an important role in this.

How can the osteopath improve the local circulation if the heart is not in an optimal state of function? The correction of cervical, upper thoracic, costal, diaphragm and craniosacral lesions*, together with stretching of intrathoracic fascial retractions, the mobilisation of the blood pressure regulating organs and advice related to diet and general lifestyle are therefore important.

Heart dysfunctions often dominate the complaint of a patient without there being a specific heart complaint as such. The osteopath can quickly identify this by way of somatic dysfunctions in the region T₁-T₅.

In this e-book, the functional anatomy, physiology and neurology are discussed as well as the heart mobility and the ways in which the osteopath deals with such dysfunctions.

For readers who are unfamiliar with the osteopathic visceral approach, please refer to Chapter 11 at the end of this e-book.

* PS: a lesion is a functional loss of mobility. The term lesion has another meaning in osteopathy than in classic medicine where it refers to a structural defect in the human structure.
2. Anatomy


2.1. Position

The heart:

• Is approximately the size of a fist and is in the thorax, above the diaphragm and left of the sternum.

• Is in the middle mediastinum (Figure 1, 2 and 3).

• Is a hollow organ that weighs approximately 300 g and has 4 chambers.

![Figure 1 - The mediastinum](image)
4. Mobility

Due to the fact that caudal surface of the heart is strongly related to the diaphragm, it will also follow the cranio-caudal movements of the diaphragm (Figure 30). (Holland et al 1998, Mc.Leish et al 2002, Peeters 2005, Porat et al 2000, Wang et al 1995)

The movement of the heart as influenced by respiration is a global translation.

During inhalation the diaphragm descends. The heart follows this displacement caudally (Figure 31).

This results in traction along the vertebropericardiac, bronchopericardiac and tracheopericardiac ligaments and along the superior sternopericardiac lig.

If these ligaments are trophically changed and their elasticity is reduced, this caudal force will be directly transferred to the spine at T₂-T₄, the sternum and the trachea and the bronchi (Figure 31). This is most likely why periostial sensitivity is so frequently found at T₂-T₄. Such vertebropericardiac traction could play an important role in complaints of the trachea, bronchi and thyroid (Figure 31).

The “thoracic outlet” is significantly influenced and “thoracic outlet” symptoms are likely to result.
6.2. Palpation

Palpation of the cardiac pulse is done with the right hand flat upon the left hemithorax; thenar and hypothenar on the sternum and the index finger under the nipple. For female patients the right hand is placed under the left breast.

The osteopath pays attention to:

- Is there a point of maximum pulsation that can be localised at the height of the apex of the left ventricle? Try to localise this point with the fingertip.

- Normally this point is the size of a coin along the midclavicular line at the height of the 5th intercostal space.

- In cases of left ventricle enlargement (previous infarct(s)) this point will be displaced laterally. An obvious enlargement can mean that the point is found along the axillary line.

- If this pulse point is not readily found this does not always indicate pathology. Palpation of the point with the patient lying on the left side can aid the palpation.

Palpation of the apex:

*Video 1 - Palpation of the apex*
7. Osteopathic Techniques

7.1. Stretch of the Intrathoracic Fascia

(Figure 52)

The patient is supine, the legs straight and with the level of T2-3 on the edge of the table. The head is supported in the hands of the osteopath.

Central fascias

The osteopath applies traction from the occiput, protecting the cervical spine by avoiding lordosis, and asks the patient to breath in deeply – first via the abdomen, then via the thorax.

The patient is requested to breath in as deep as possible, to hold the shoulders against the table and to avoid any lumbar lordosis.

This is repeated until less caudal resistance is felt via the head.

Lateral fascias

The osteopath brings the head of the patient into opposite sidebending (C7) and ipsilateral rotation (C6), gives traction on the occiput, protecting the cervical spine by avoiding lordosis, and asks the patient to breath in deeply – first via the abdomen, then via the thorax while holding the shoulders against the table.

This is repeated until less caudal resistance is felt via the occiput.

If, after four repetitions, the fascias are not loosening there are musculoskeletal lesions that are limiting the motion. These must be corrected.

Video 8 - Stretch of the intrathoracic fascia
9. About the Authors

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Both authors are holders of university degrees, namely the Master of Science in Osteopathy – University of Applied Sciences, and are very active with the promotion and academic structuring of osteopathy in Europe. In 1987 they began The International Academy of Osteopathy (IAO) and are, to this day, the joint-principals of this academy. The IAO is since several years the largest teaching institute for osteopathy in Europe. Both osteopaths are members of diverse professional organisations, including the American Academy of Osteopathy (AAO), the International Osteopathic Alliance (IOA), the World Osteopathic Health Organisation (WOHO), as part of their mission to improve osteopathic development.

This osteopathic encyclopaedia aims to demonstrate the concept that a proper osteopathic examination and treatment is based upon the integration of three systems: the musculoskeletal, visceral and craniosacral systems.
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