



# DO for the MD

OMM/OMT/NMM

What are those osteopaths doing?

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# Objectives

- 1) Know what OMM/OMT/NMM means and the various techniques this encompasses.
- 2) Know what types of common clinical conditions seen in family medicine that can be referred to a DO for manual treatment
- 3) Learn a couple of simple osteopathic manipulation techniques any physician could utilize with a patient.

# Definitions:

- ▶ OMM = Osteopathic Manual Manipulation
- ▶ OMT = Osteopathic Manual Therapy/Treatment
  - ▶ OMM and OMT are the same thing, just different phrasing
- ▶ NMM = NeuroMuscular Medicine
  - ▶ Slightly different term. Typically used by providers who have done additional training

# Osteopathic medical school training

- ▶ All osteopathic students learned basics during our first 2 years of medical school. I cannot speak for all schools but, typically 4 hour class weekly. With 200+ hours by the time an osteopath graduates.
  - ▶ This is often called OPP – osteopathic principles and practices
- ▶ What did we do during this time?
  - ▶ Reviewed osteopathic principles
  - ▶ Reviewed anatomy
  - ▶ Lear how to palpate and locate abnormalities
    - ▶ TART = Tissue texture changes/Asymmetry/Restriction/Tenderness
  - ▶ Learn how to verbalize/document finding
  - ▶ Learned a variety of techniques and what they are/how they work
  - ▶ Practice – the hands on / how to - on our classmates

# What techniques are taught in school?

## Direct

- ▶ HVLA – high velocity low amplitude
- ▶ Muscle energy
- ▶ Articular
- ▶ Soft tissue
- ▶ Myofascial Release Technique

## Indirect

- ▶ Counterstrain
- ▶ FPR – Facilitated Positional Release
- ▶ BLT – Balance Ligamentous Tension/Technique

## Other

- ▶ Cranial
- ▶ Lymphatics
- ▶ Chapman points

# Direct techniques

- ▶ HVLA – high velocity low amplitude
  - ▶ Similar to the classic chiropractor adjustment
- ▶ Muscle energy
  - ▶ find first restrictions in a tight muscle, have patient contract the muscle against resistance (extremity won't move), have patient release contraction, wait for post contraction relaxation phase (a couple seconds), then move to next barrier
  - ▶ Common – PT, massage therapists, coaches/gym trainers, etc.
- ▶ Articulatory
  - ▶ Move joint physiological motion
  - ▶ PT or massage therapy
- ▶ Soft tissue - massage
  - ▶ PT or massage
- ▶ Myofascial Release Technique
  - ▶ Manipulation of the fascia and muscle tissue
  - ▶ PT or massage

# Indirect

- ▶ Counterstrain – technically called Strain-Counterstrain but we ALL shorten
  - ▶ Locate a tender point, shorten the muscle, wait for it to release (90 seconds)
  - ▶ I often describe this as similar to turning off one's cell phone or computer when it starts acting quirky
- ▶ FPR – Facilitated Positional Release
  - ▶ Find "neutral", compress through the joint, then move into the direction of ease
- ▶ BLT – Balance Ligamentous Tension/Technique
  - ▶ "balance" to the point of ease for a structure and wait for it to release

# Other

- ▶ Lymphatics
  - ▶ PT or massage
- ▶ Cranial
  - ▶ Only the very basic of concepts taught in schools
  - ▶ Additional training needed even for osteopaths
  - ▶ Very controversial for osteopaths – Dr. Upledger went and taught massage therapist
- ▶ Chapman points
  - ▶ More academic than anything

# Beyond school – additional techniques providers may have learned

- ▶ Cranial – much more in depth
- ▶ Biodynamics (very common in the state of Maine)
- ▶ Torque Unwinding
- ▶ Fascial Distortion Model (FDM)
- ▶ Likely there are some more niche techniques I don't know of

# Training of each Osteopath:

Each osteopath will likely rely on certain techniques more than others.

- ▶ This is partially provider dependent – each provider will preference certain techniques over others
- ▶ The school they went to often will influence – some school are stronger is certain techniques than others based on staff preferences
- ▶ Additional training outside of our standard curriculum

Training differences:

- ▶ Residency experiences can vary widely and may be specialty dependent
  - ▶ Osteopathic distinctiveness designation ~ even this varies widely
- ▶ OMM/NMM residency – 3 years, with intern medical year and 2 dedicated years of manipulation
- ▶ +1 OMM/NMM fellowship – can be done after completing a residency
  - ▶ Often FM and PM&R residency – but, not limited to these specialties

# What can we treat?

- ▶ Musculoskeletal issues
  - ▶ Various musculoskeletal issues
    - ▶ Yes, we see LOTS of back/neck pain
    - ▶ Think of us particularly if they got better with PT but, did not resolve - when work up does not indicate ortho/neurosurg/PMR
  - ▶ Fibromyalgia / chronic pain
  - ▶ Arthritis – we can often help decrease pain and improve function – even when surgery is indicated – but, if there is a delay in getting surgery OMT may help in the mean time
- ▶ Headaches
- ▶ Constipation
- ▶ Rib or breathing difficulties – clearly standard medication management first
- ▶ And more – I get a lot of odd presentations for which the work up is negative and no one knows what is going on and I can often create change.

# There are relative contraindications

- ▶ Unstaged cancer or in the midst of cancer treatment
  - ▶ There is a concern in improving lymphatic drainage could increase cancer spread
- ▶ Rheumatoid arthritis/Down syndrome
  - ▶ Certain direction techniques need to be avoided – but, lots we can still do
- ▶ Acute Fracture – I cannot fix the fracture but, if appropriately casted or splinted I may treat the rest of the body
- ▶ Common sense – adjust treatments to injuries with ROM limitations

# When the ACGME and AOA residency match merged:

- ▶ As a part of this merger the AOA agreed to create pathways to allow MDs to learn and practice osteopathic manipulation techniques

# Osteopathic practice:

- ▶ Evidence: many small studies and some RCTs. Most are neutral or positive – thus we are not doing harm
- ▶ Why do we keep doing this:
  - ▶ because our patients like it
  - ▶ they keep coming back
  - ▶ I have helped people feel better before they leave my office.
- ▶ There are osteopaths who only practice OMM
- ▶ I blend with my family medicine.
  - ▶ I have been at my current office for almost 2 year. I have reserved 4 hours, with 8 appointments per week with a current OMT panel of just over 100 patients – and growing. For chronic issues often I would prefer to see every 4 weeks, most are every 6-8 weeks due to scheduling and my waitlist is 6-8 months for an eval.

# Before treating:

- ▶ I always get permission: OMT is considered a procedure.
  - ▶ Informed consent
    - ▶ Post procedure pain or worsening function
    - ▶ Technically I could do structural damage – as per any manipulation. The techniques I do damage is HIGHLY unlikely and I have not done any but, particularly HVLA has the potential
    - ▶ Unless specified treatment should not be painful or uncomfortable. Make provider aware if there is an issue so treatment can be modified
  - ▶ Post procedure recommendations
    - ▶ May be sore after – typically OTC meds will be sufficient
    - ▶ Take it easy for 24-72 hours after a treatment
    - ▶ Drink an extra glass of water

Lets get hands on!



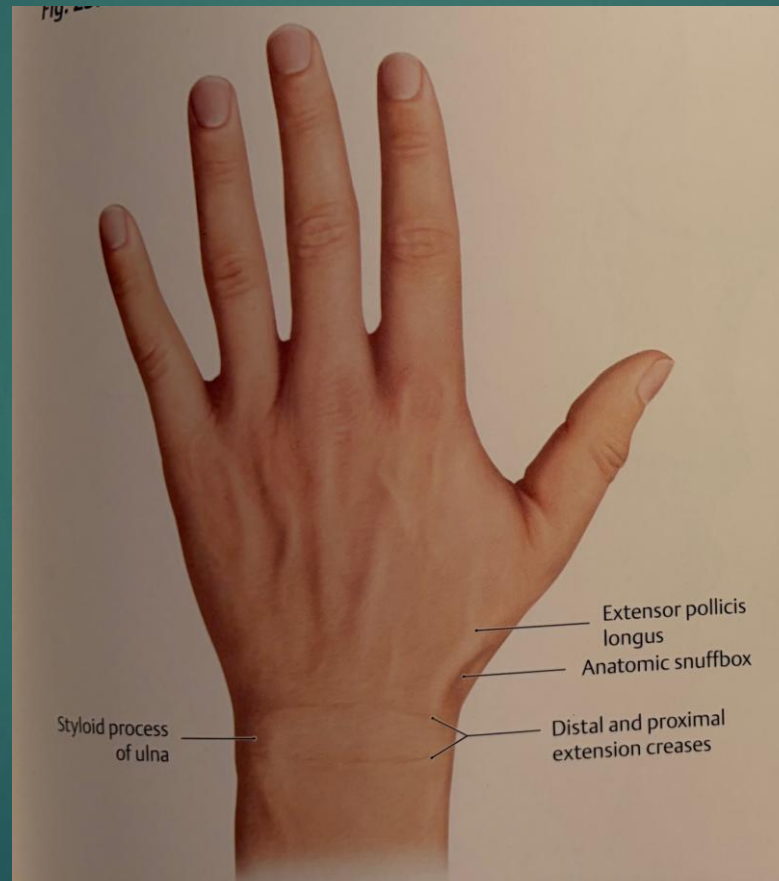
# OMM techniques for today:

- ▶ Wrist - articularatory
- ▶ OA release – myofascial technique
- ▶ Rib raising – myofascial technique

# Wrist articulatory technique

- ▶ When to use: wrist pain - trauma/fracture ruled out
  - ▶ Consider this similar to manipulation to reset a nursemaid elbow but, not radiographic findings
- ▶ Landmark: prominent styloid process of the ulna or dropped metacarpal bones when palpating the posterior aspect of the wrist/hand
- ▶ Provider action: stabilize interosseous membrane between the ulna and radius
- ▶ Patient directions: make LARGE, SLOW circles of the wrist/hand. They will make 2 complete rotations in both directions but, request you state when to change directions. Observe and make sure they do not make a fist (keep fingers long).

# Review anatomy

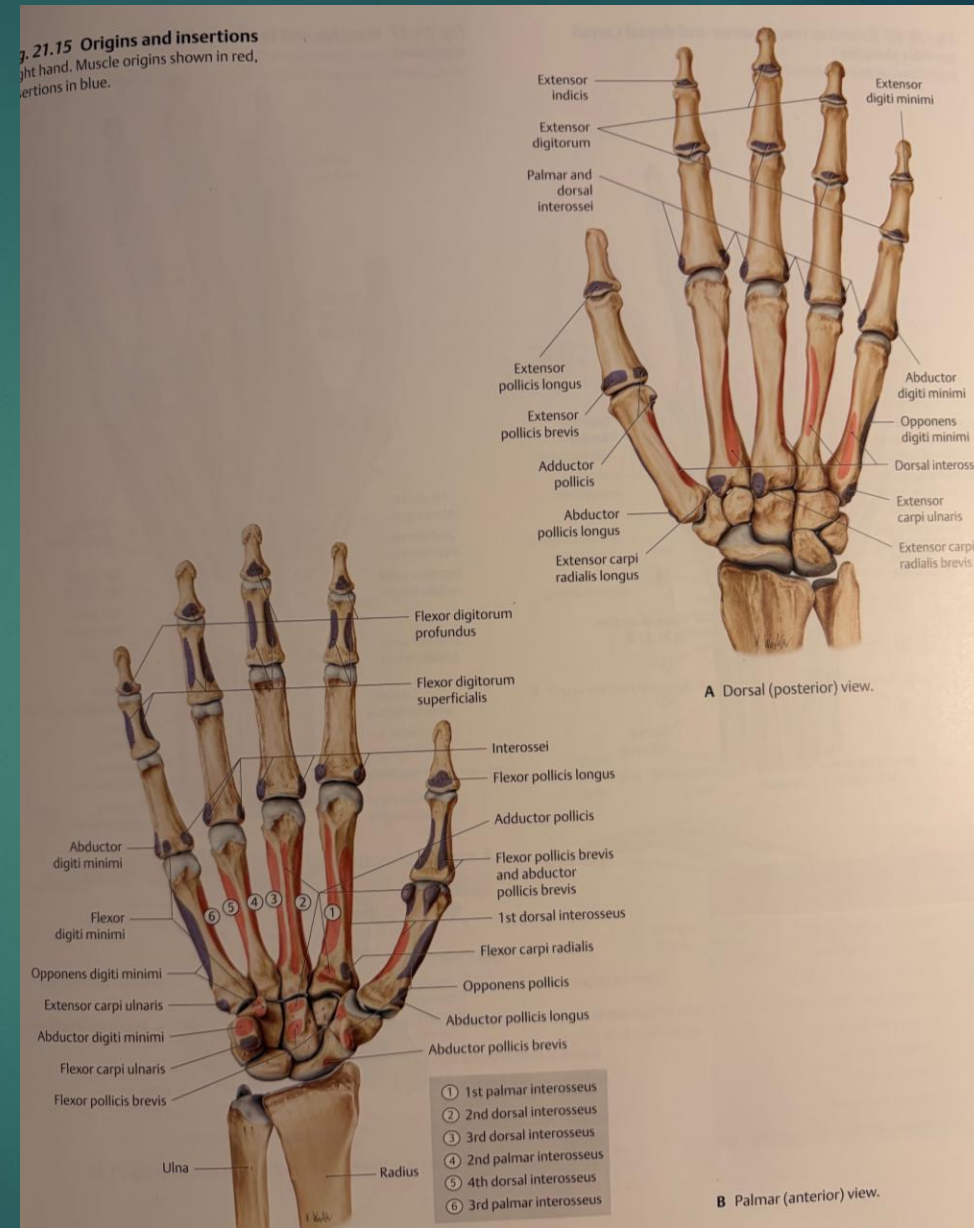


# Review anatomy



# Anatomy Review

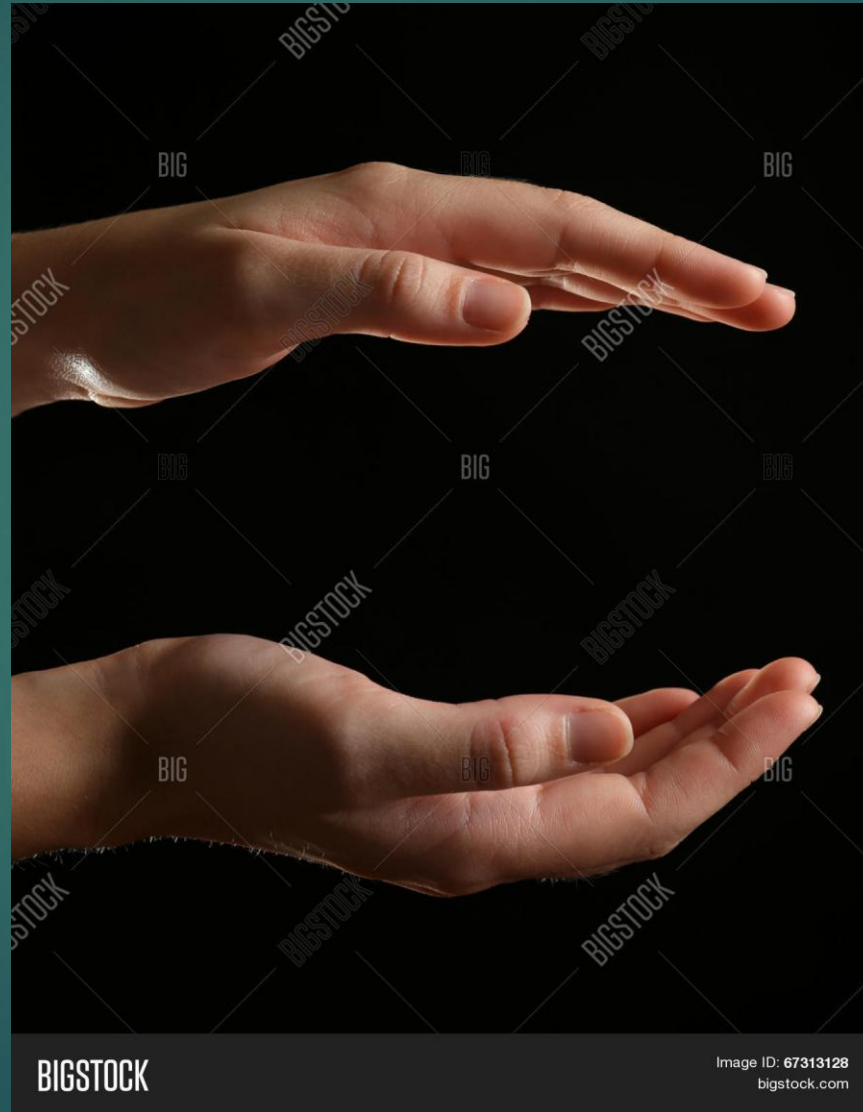
7-21.15 Origins and insertions of the muscles of the right hand. Muscle origins shown in red, insertions in blue.



A Dorsal (posterior) view.

B Palmar (anterior) view.

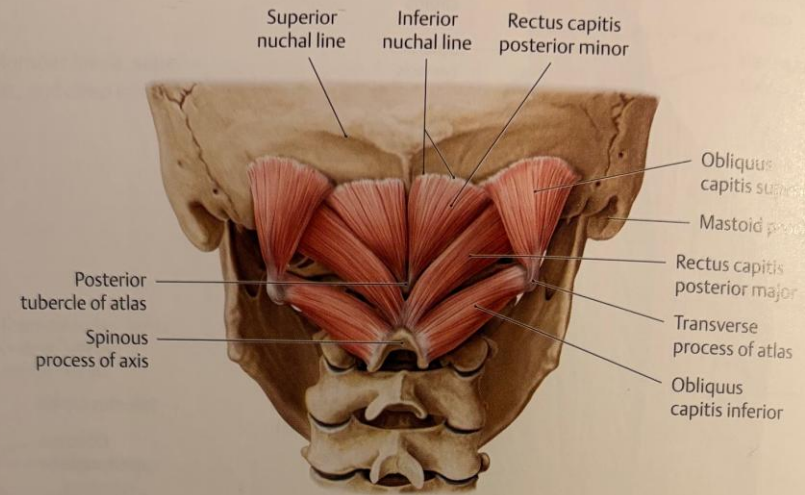
Lets try it!



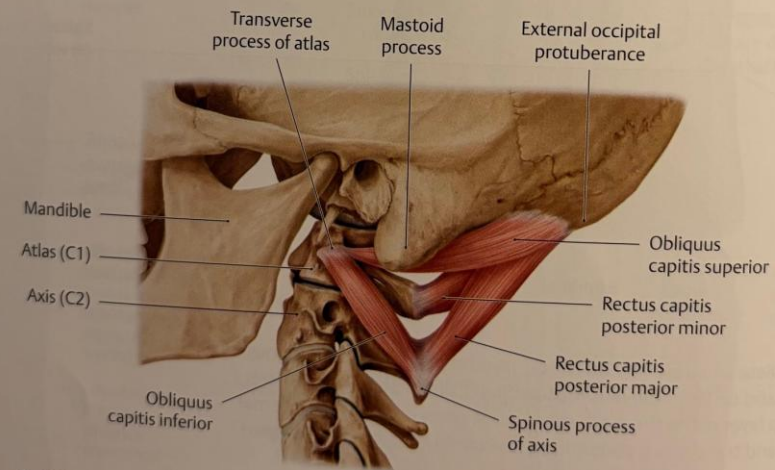
# OA release

- ▶ Myofascial technique to decrease muscle tension at the base of the skull. Good for neck pain and tension headaches.
- ▶ Position: patient is laying supine – can also be reclined if in a hospital bed or unable to lay down fully (i.e.: CHF exacerbation)
- ▶ Make sure patient is communicating with you. If this becomes painful and they feel they are tensing up then provider needs to back off.
- ▶ Action: press into the muscles and fascia at the base of the skull and provide gentle traction.

# Anatomy review deep muscles

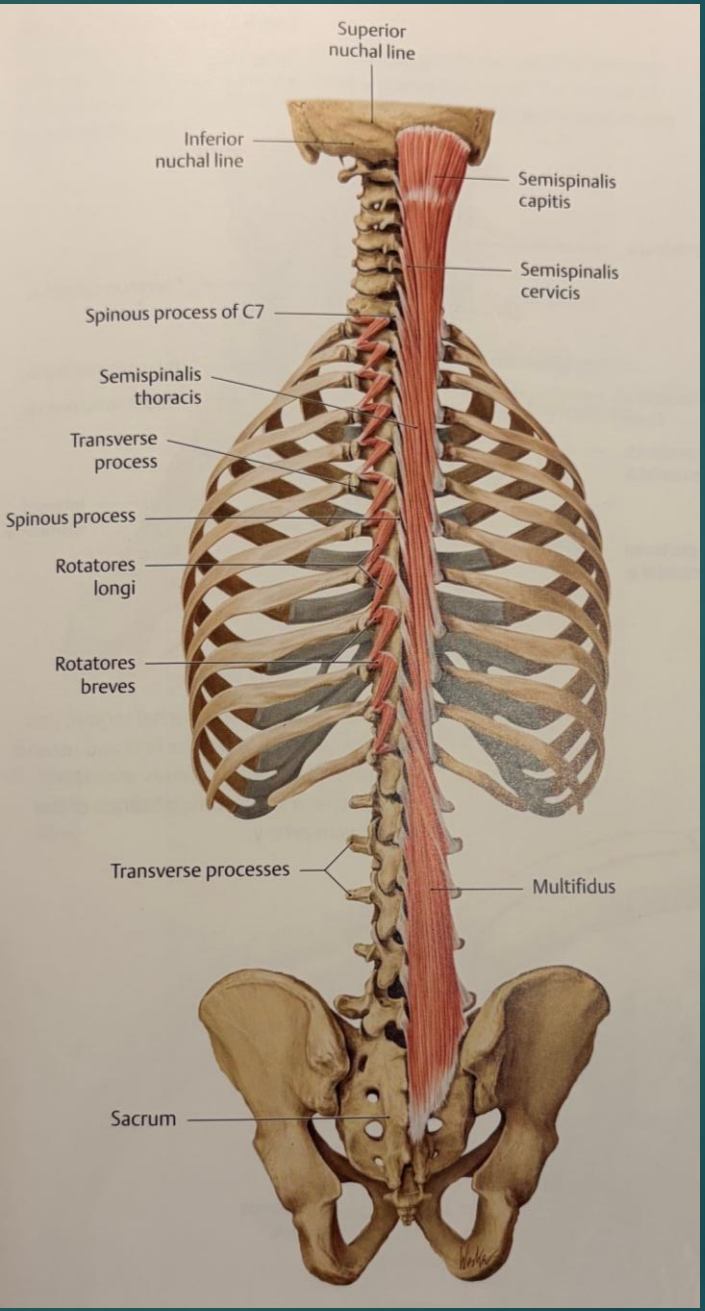


B Suboccipital muscles, posterior view.

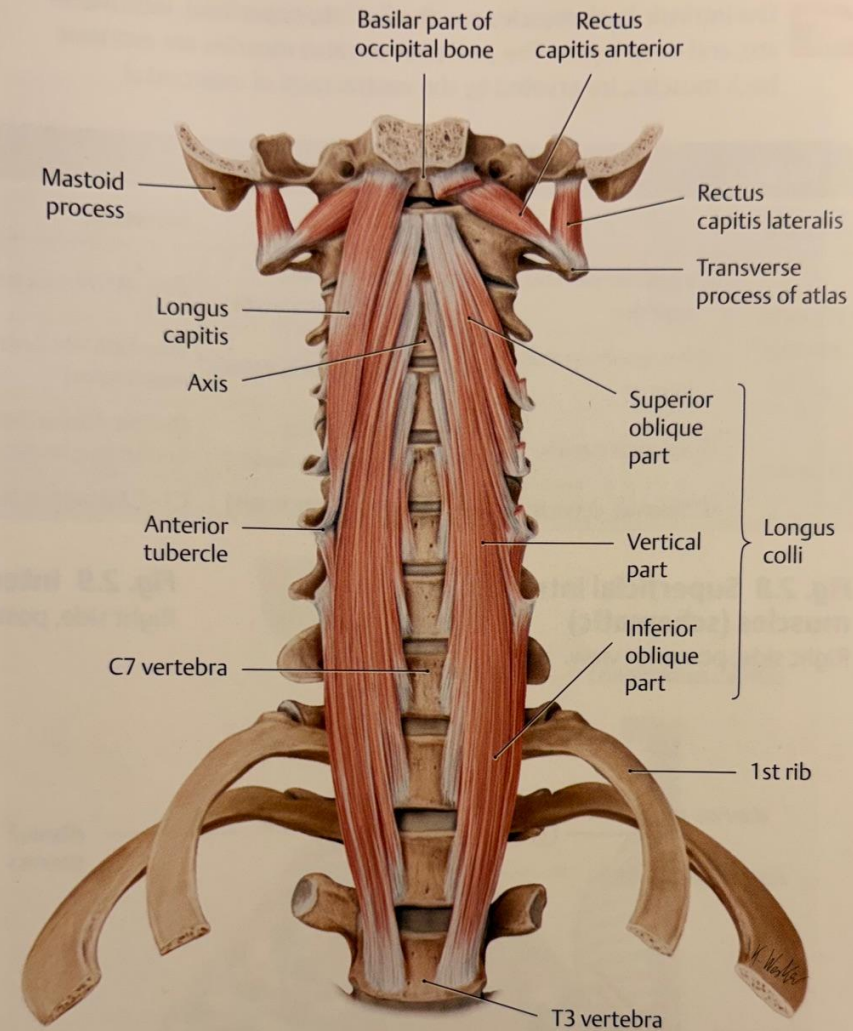


C Suboccipital muscles, left lateral view.

# Anatomy Review:

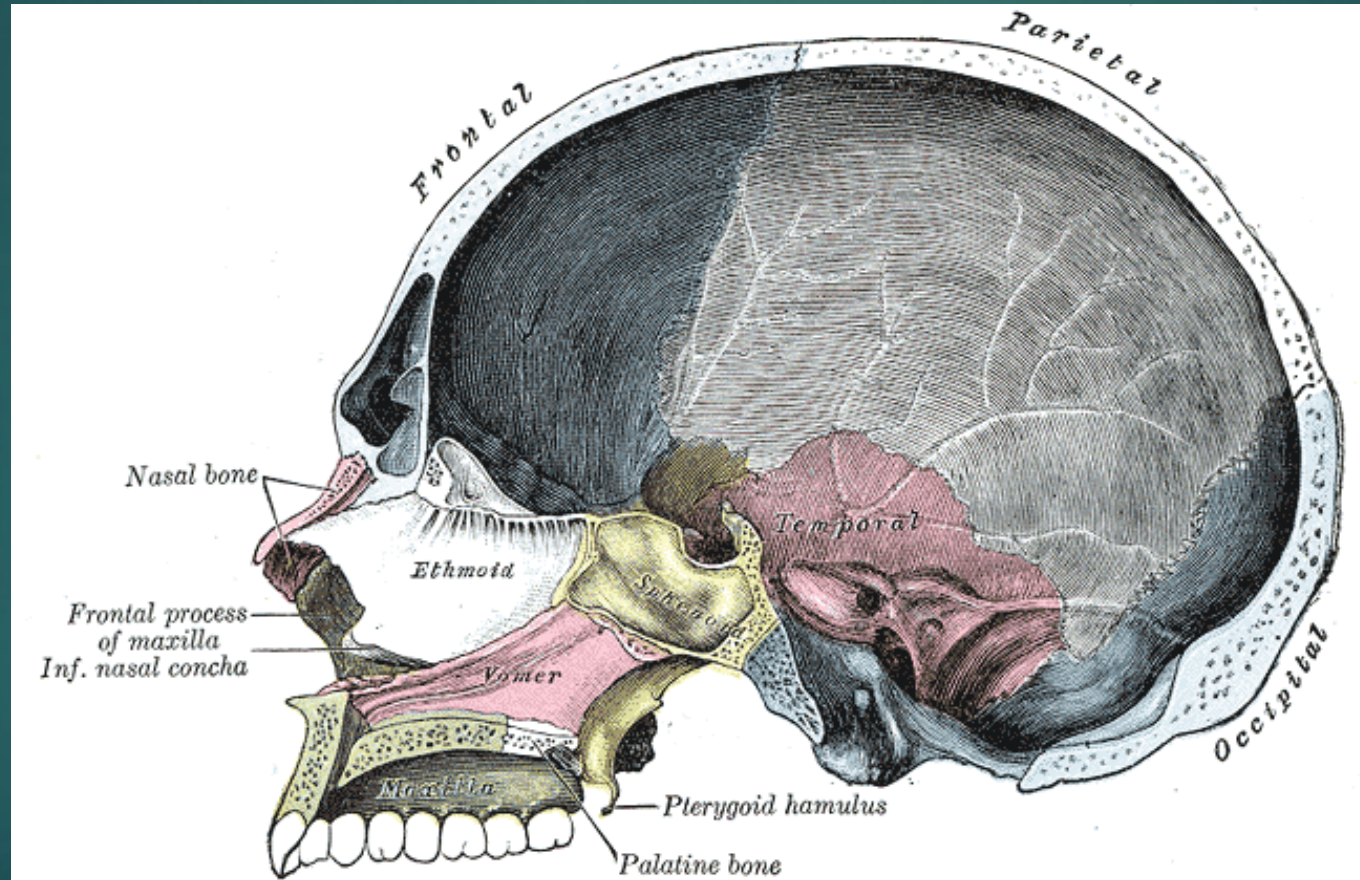


# Anatomy Review: anterior neck



**B** Prevertebral muscles, anterior view.  
*Removed:* Longus capitis (left); cervical viscera.

# Lets try it!

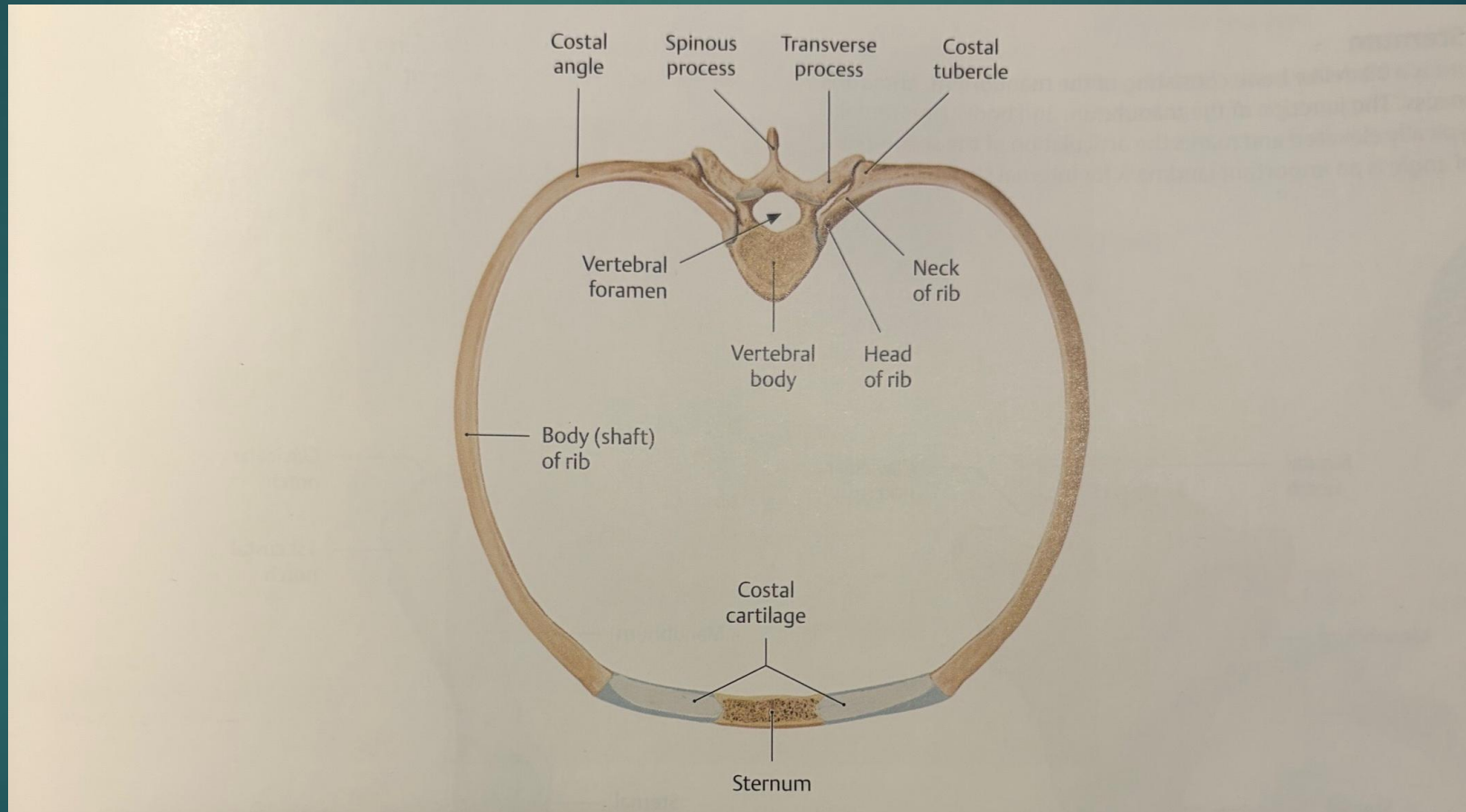


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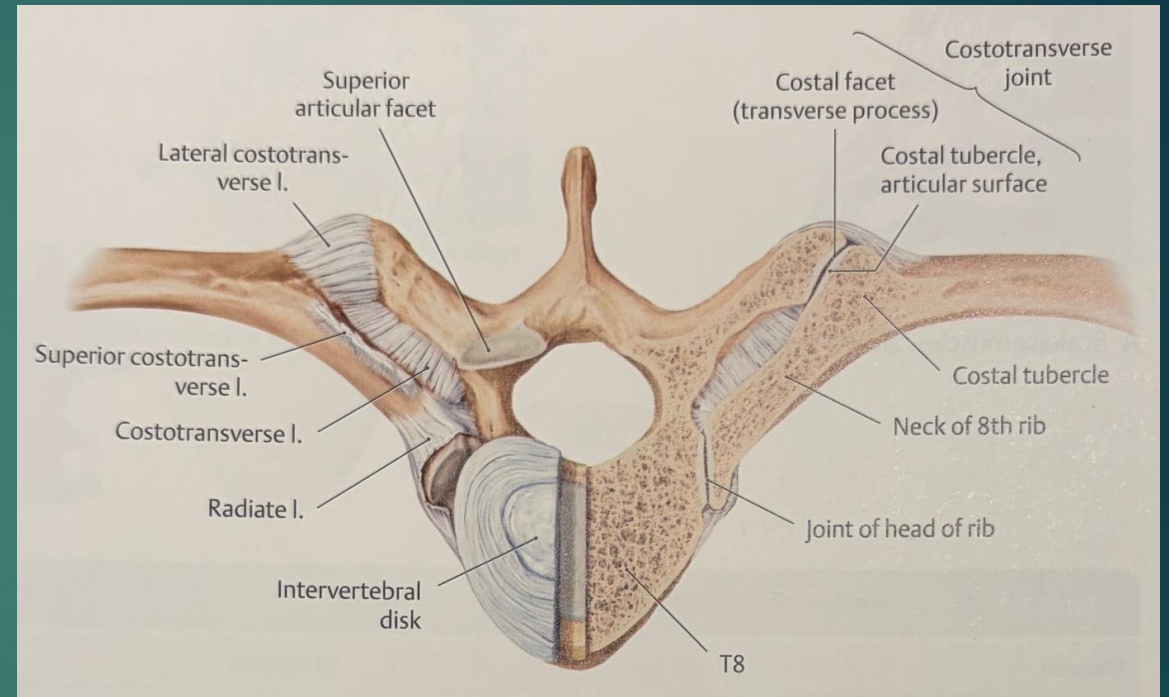
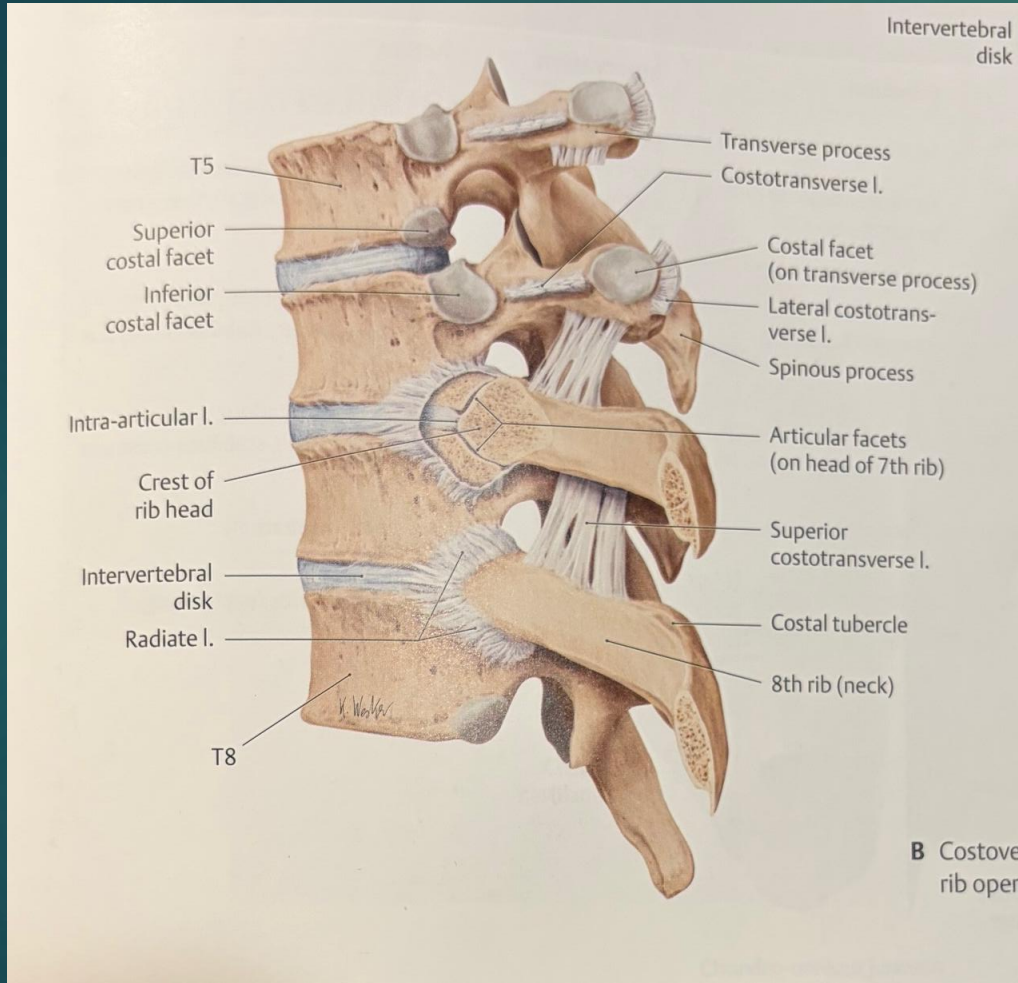
# Rib Raising

- ▶ Patient is laying supine – or reclined (similar to OA release)
- ▶ Provider will locate the posterior rib, medial to the costal angle with fingertips then press up gently before providing gentle traction laterally by leaning back. You will tire out if you pull with your arms.
  - ▶ Can do at multiple locations if needed
  - ▶ This is my favorite to do when I have a medical student so they can do on the other side with me

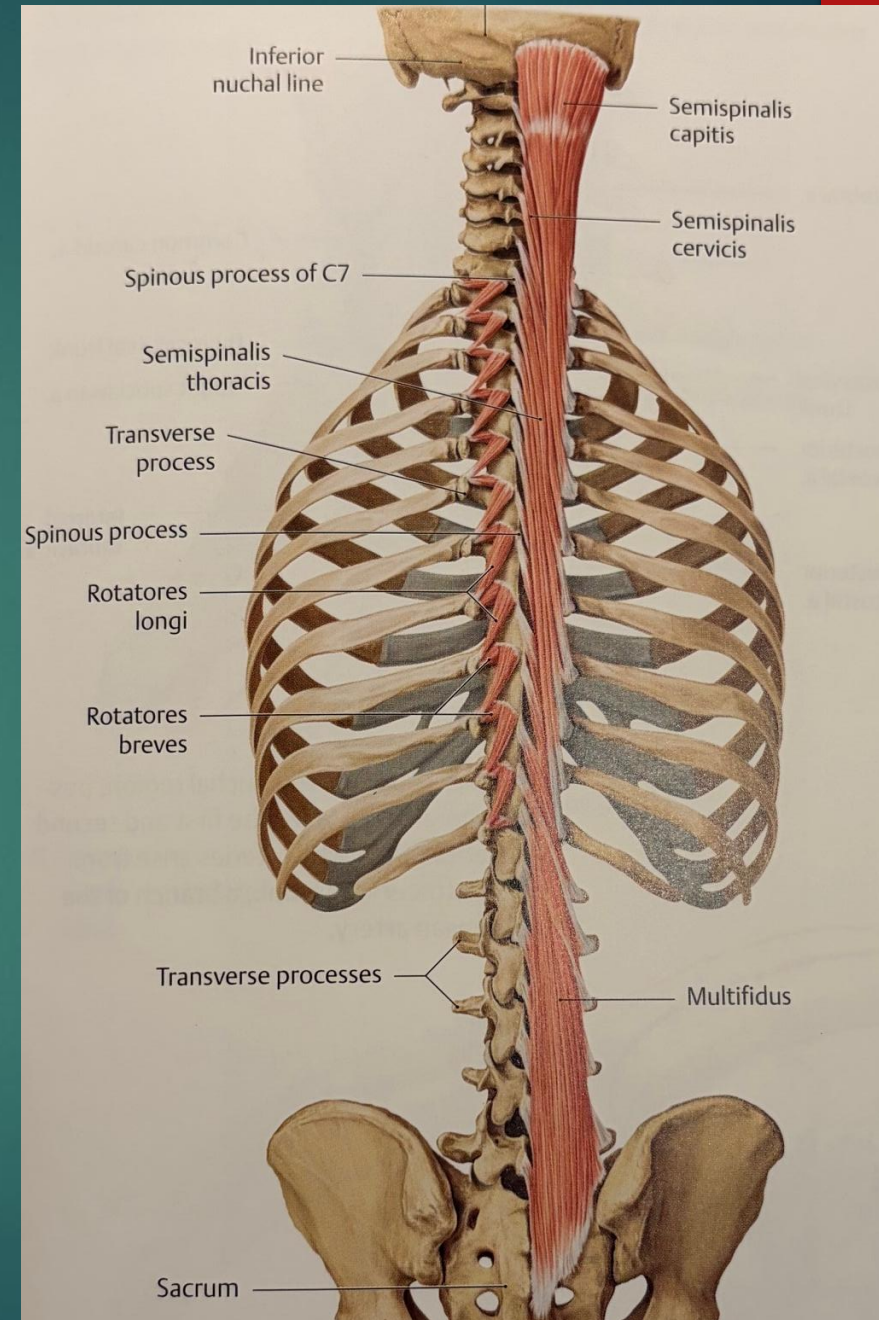
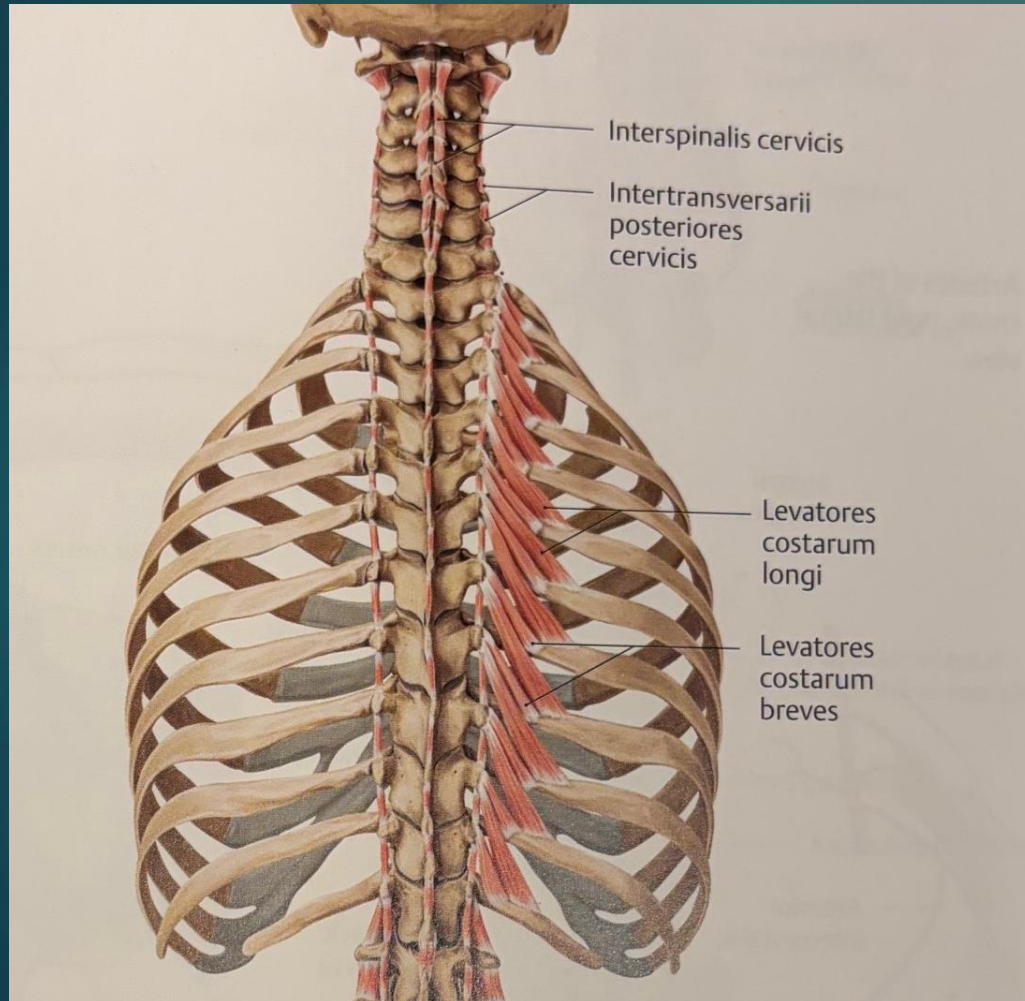
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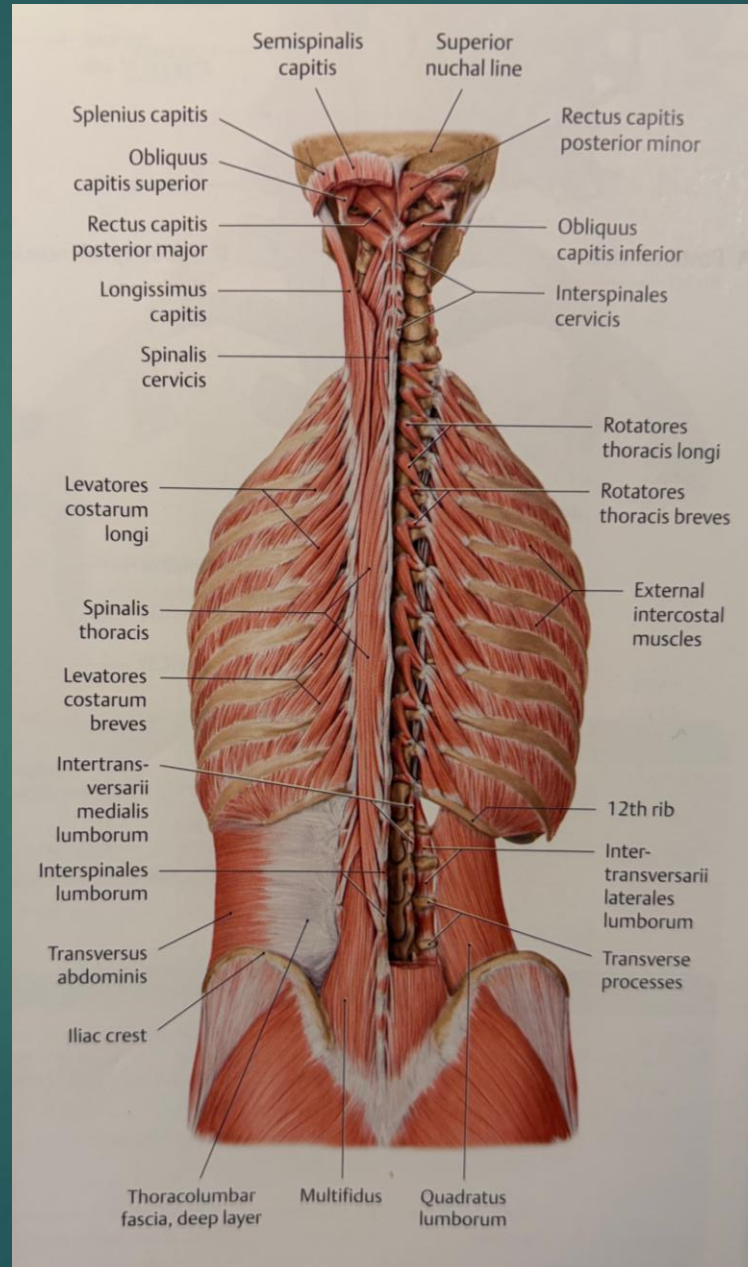
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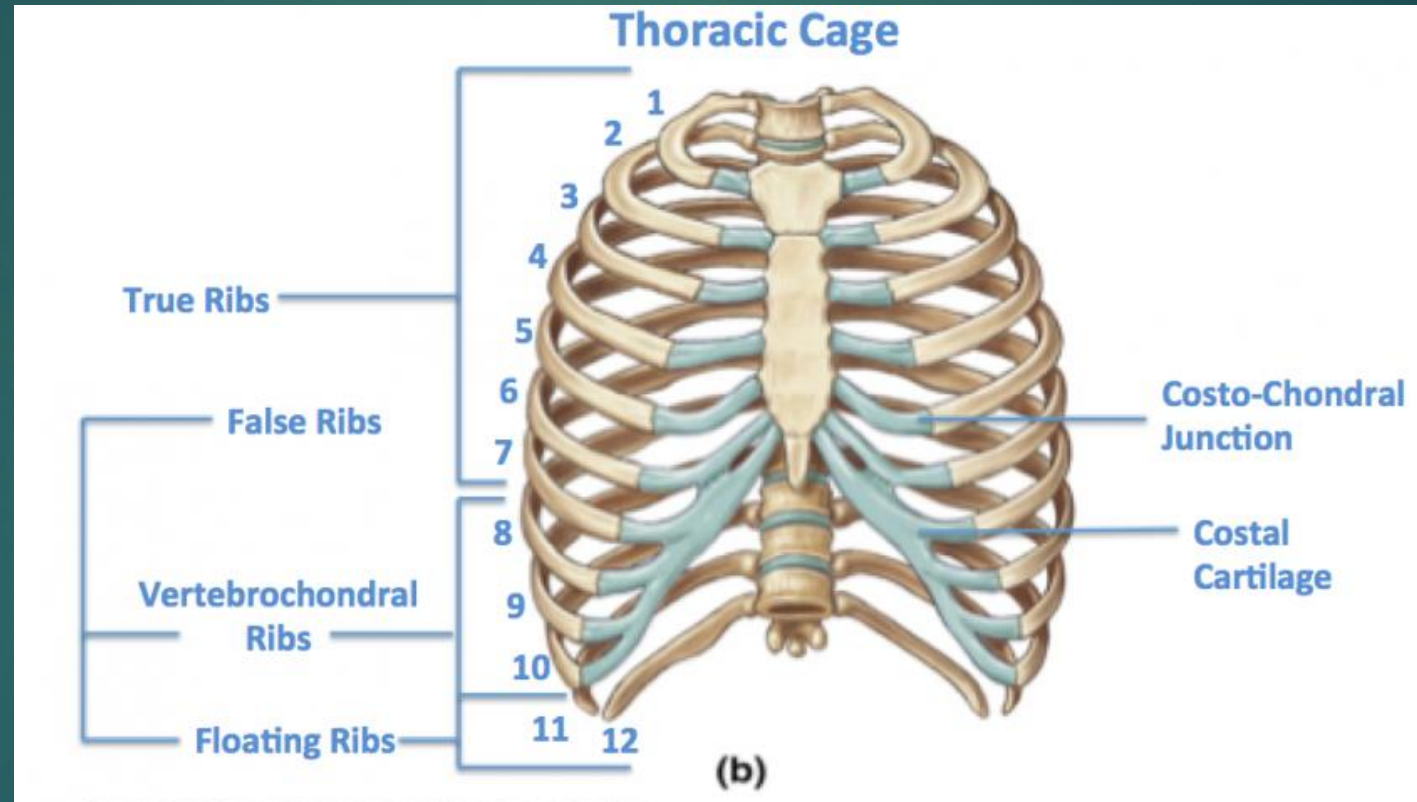
# Anatomy review



# Anatomy Review



# Lets try it!



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# Review:

- ▶ OMM/OMT and NMM – all terms for osteopathic manipulation
- ▶ Many different techniques and no 2 osteopaths will treat exactly the same.
- ▶ Osteopaths treat a lot more than just back pain.

# references

- ▶ Gilroy, A. M., MacPherson B. R., Ross, L.M., (2008) *Atlas of Anatomy*. New York, NY: Thieme
- ▶ University of New England College of Osteopathic Medicine staff and fellows, (2011) *Osteopathic Principles & Practice 5<sup>th</sup> Edition*. Biddeford, ME: UNECOM

# Questions?



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