lymphatics

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Case Report

Immediate Quantitative Sensory Testing of the Fascial Counterstrain Method: A Case Study

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Abstract

Quantitative sensory testing (QST), including temporal summation of pain (TSP) and pressure pain threshold (PPT) assessments, was conducted to evaluate the diagnostic validity and immediate therapeutic efficacy of the manual therapy technique Fascial Counterstrain (FCS). A single patient with persistent lower back and referred leg pain was evaluated and treated by a certified FCS practitioner. A clinical diagnosis of left S1–S2 radiculitis (FCS criteria) was established and corroborated by elevated pre-treatment TSP and reduced PPT measures in the affected dermatomes, indicating nerve root irritation and central sensitization. Immediate post-treatment TSP and PPT assessments demonstrated near-complete normalization of wind-up in the involved S1 and S2 dermatomes, along with a substantial improvement in three-trial-average PPT measurements of the S1–S2 musculature from 2.4 kg/cm^2 to 6.1 kg/cm^2. This case report provides preliminary evidence supporting the diagnostic process and immediate post-treatment efficacy of FCS in patients with lower back pain and central sensitization.

Keywords: Fascial Counterstrain; lymphatic drainage; central sensitization; quantitative sensory testing; chronic pain; pain pressure threshold testing

1. Introduction

The treatment of chronic pain places a significant burden on the United States healthcare system, with estimated annual costs of approximately USD 723 billion (or about USD 2200 per person). Musculoskeletal pain, as the leading cause of disability in the United States, is a substantial contributor to these costs [1,2].

One novel, non-pharmacological intervention that is increasingly utilized in the clinical management of musculoskeletal, visceral, and vascular dysfunction is *Fascial Counterstrain* (FCS). FCS, which evolved from the osteopathic technique *Strain and Counterstrain*, is a multisystem, anatomically based manual therapy, proposed to reduce peripheral nociceptor activation through the modulation and normalization of regional lymphatic flow (for review, see [3]). As an *indirect manual therapy* technique, FCS treatments employ gentle, non-force positioning and/or tissue decompression to improve circulation and reflexively correct dysfunction [4,5]. This contrasts with *direct manual therapy* techniques that apply force directly against restrictive barriers to improve mobility and/or reduce pain [5].

Check for updates

Academic Editor: Varsha Gandhi

Received: 28 December 2025
Revised: 10 February 2026
Accepted: 20 March 2026
Published: 26 March 2026

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1.1. Background

The goal of FCS treatments is to identify and remove regions of interstitial inflammatory stasis (IIS), theorized to create and maintain chronic somatic, visceral, and vascular dysfunction through the persistent chemical excitation of peripheral nociceptors. Once inflamed, deep tissue nociceptive sources are theorized to produce loci of cutaneous tender points (TPs) by activating dorsal root reflexes and promoting central sensitization (for review, see [6]). This physiological process has led to the theoretical association of FCS TPs with specific underlying (inflamed) *anatomical source tissues*, including muscles, ligaments, nerves, vessels, and organs. A correlational process that purportedly involved the palpatory assessment of all segmentally related tissues that could neurogenically produce the observed TP, based on previously established anatomical and segmental correlations [3,7,8].

The described *anatomical correlation* of TPs enables FCS to serve a dual role in both the diagnosis and treatment of multi-system fascial dysfunction. The process of TP palpation identifies the inflamed tissue (e.g., makes the diagnosis), leading to TP-specific treatments. Notably, a recent study provided direct clinical support for the IIS hypothesis in complex regional pain syndrome patients by demonstrating that these individuals have impaired lymphatic drainage and autonomic dysfunction from the accumulation of interstitial pro-inflammatory cytokines [9]. Additionally, Counterstrain techniques have also been investigated at the cellular level and found to reduce pro-inflammatory cytokine production following trauma. Specifically, an experimentally induced repetitive strain model demonstrated a 46% reduction in fibroblast interleukin-6 production in the Counterstrain treatment group as compared to controls [10].

1.2. FCS and the Lymphatic Pump Mechanism

Manual tissue decompression (performed during FCS treatments) is believed to create an interstitial *vacuum* that enhances the lymphatic system's own pressure-driven "suction mechanism", an essential component in the transportation of pro-inflammatory cytokines from the interstitial space to initial lymphatic vessels [11]. This supports the contention that FCS treatments have the potential to restore the function of the local lymphatic pump mechanism, known to be inhibited by the presence of specific, interstitial pro-inflammatory cytokines, including interleukin-1β, tumor necrosis factor alpha, and interleukin-6 [12]. Once lymphatic pump function has been restored, nociceptive signaling to the dorsal horn can be anticipated to reduce as regions of IIS gradually dissipate. This may, in turn, alleviate all associated muscle guarding and/or somato-sympathetic reflexes [13,14] that can alter segmental mobility and impair regional vascular perfusion.

1.3. Research Gaps and Study Objectives

Recent randomized controlled trials and meta-analyses of indirect manual therapies, including Counterstrain and the Positional Release Technique, demonstrate short-term pain (VAS) reductions of 20–68% (e.g., in patients with low back myofascial pain syndrome) when compared to controls or when combined with exercise [15–17]. Although preclinical evidence also supports Counterstrain's modulation of pro-inflammatory cytokines (as previously cited), quantitative validation of FCS's diagnostic accuracy and immediate post-treatment therapeutic efficacy is lacking. This case report addresses this gap using TSP and PPT; however, it cannot directly confirm the IIS hypothesis, as post-treatment cytokine levels and lymphatic flow were unmeasured.

TSP testing is a non-invasive method of assessing sensory perception by measuring an individual's response to specific stimuli, including pinpricks. More specifically, it aims to quantify sensory thresholds and detect abnormalities such as hypoesthesia or hyperalgesia. With regard to the central nervous system, it can reveal enhanced sensory

processing, including "wind-up" or temporal summation [18]. Wind-up is a neuroadaptive phenomenon that shares several physiological manifestations with central sensitization, including the expression of hyperalgesia and receptive field expansion. More specifically, it can be defined as a frequency-dependent increase in neuron excitability, characterized by a progressive acceleration in (neuron) response to a series of repetitive stimuli delivered between 0.5 and 3 Hz [19]. PPT assessment differs from TSP testing in that it uses a pressure algometer to determine the minimum force necessary to elicit the sensation of pain at a given anatomical location. PPT is therefore an indirect measure of pain sensitivity, used to identify regions with altered nociceptive processing, by combining deep tissue pressure stimulation with real-time patient feedback [20].

In this quantitative case study, *FCS's diagnostic validity* was demonstrated by correspondence between the FCS clinical diagnosis and pre-treatment TSP sum scores (elevated wind-up from 10 repetitive pinprick stimuli), indicating central sensitization [21].

Immediate *FCS therapeutic efficacy* was determined by a >1.5 kg/cm^2 post-treatment increase in PPT measures (exceeding reported minimum detectable changes) [22] and a >50% reduction in TSP wind-up sum scores, aligning with the Baeumler et al. (2019) criteria for clinically meaningful pain reduction in patients with high temporal summation [23].

2. Detailed Case Description

The subject was a 22-year-old, non-smoking, 6'5', Caucasian lacrosse player who presented with central lumbosacral pain that radiated intermittently into the left sciatic notch and hamstring region. Pain onset was insidious and estimated to begin on 1 May 2023. At the time of treatment, 16 July 2023, the subject reported taking no medication and rated his pain at 6/10 (VAS score). His past medical history was remarkable for several minor sport-related injuries, including a left mid-shaft fibula fracture. Previous treatment for this episode consisted of over-the-counter anti-inflammatory medication (short-term) and one session of physical therapy where he was prescribed core stabilization and hip flexibility exercises. The patient reported performing the prescribed exercises for several weeks; however, he eventually stopped due to a lack of symptom improvement. A Modified Oswestry Low Back Pain Scale was also administered on 16 July 2023, indicating 10% disability, including limitations in prolonged walking, standing, traveling, and athletic participation.

2.1. Materials and Methods

The FCS diagnostic process resulted in a clinical diagnosis of S1, S2 radicular pain or radiculitis. The identified TPs included those related to the L4-S2 spinal veins; S1, S2 epidural adipose tissue; S1, S2 epidural (meningovertebral) ligaments; and a left extended fibular dysfunction (subluxation), which may have contributed to the patient's symptoms via its known attachments to the common fibular nerve [24]. The patient underwent no additional diagnostic testing prior to the FCS treatment session. All mobility testing and TP palpation procedures were performed by the primary author, a certified FCS practitioner and originator of the FCS technique.

Following the FCS evaluation process, pre-treatment PPT and TSP measurements were taken by a separate practitioner (physician) trained in both evaluation tools. This included PPT measurements of the bilateral flexor hallucis brevis muscles (S1 and S2 myotome) and TSP testing of multiple nerve distributions corresponding to the bilateral S1 and S2 dermatomes. A singular, 40 min FCS treatment session was then performed to address the identified dysfunctions, including treatment of the bilateral S1, S2 epidural ligaments [25]; bilateral S1–S3 epidural adipose [26]; bilateral L4-S2 spinal veins [27]; and left extended fibula dysfunction [28]. See the example treatment in Figure 1a,b.

FCS Treatment for extended fibular (periosteal) dysfunction

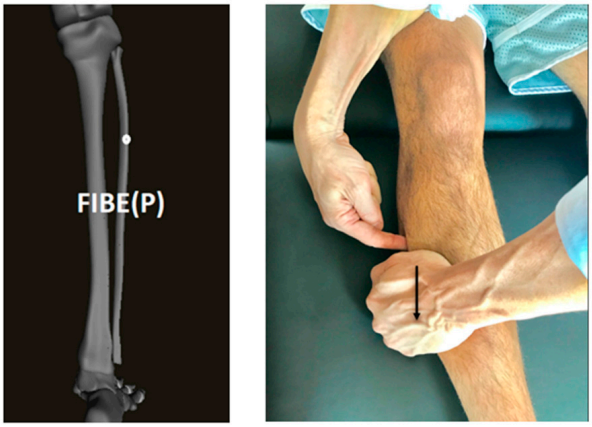
Tender Point: Located over the superior 1/3 of the posterolateral aspect of the fibula. Approach TP from posterolateral to anteromedial.

Treatment: Patient supine or seated.

Glide: The mid-fibula in a posterolateral and inferior direction

Symptoms: Calf pain, ankle pain/ ROM loss, loss of calcaneal eversion, knee pain, ankle tendonitis, sciatica.

Tender Point (TP) **Treatment**



(**a**)

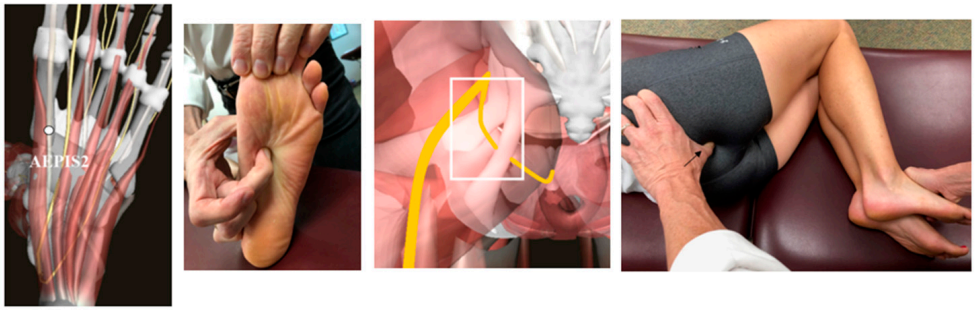
FCS treatment for anterior epidural ligament dysfunction of S2

Tender Point: Located over the proximal, lateral aspect of the Flexor Hallucis brevis muscle (just distal to the 1st metatarsal base.) Approach TP lateral to medial utilizing a snapping motion.

Treatment: Side lying in hook lying, supine or prone.

Glide: Of the Pudendal nerve (medial to the sacrotuberous ligament) in an inferior and slightly medial direction.

Symptoms: SI dysfunction, Foot pain, pelvic floor dysfunction / pain (e.g. hypertonicity of iliococcygeus), pudendal neuralgia.



(**b**)

Figure 1. (**a**). Facial Counterstrain treatment for extended fibular dysfunction. (**b**) Facial Counterstrain treatment for anterior epidural ligament dysfunction of S2.

Immediately following the 40 min treatment session, post-treatment PPT and TSP measurements were repeated for the previously tested myotomes and dermatomes. A

comparative summary of the pre- and post-treatment PPT and TSP measurements is listed in Table 1.

Table 1. Pre and Post-treatment PPT and TSP (wind-up) Measurements.

PPT Measurements		
(a)		
Pressure Pain Threshold (PPT) Testing Location	Pre-Treatment Measurement	Post-Treatment Measurement
Flexor Hallucis Brevis Left (test 1)	2.3 kg/cm^2	6.5 kg/cm^2
Flexor Hallucis Brevis Left (test 2)	2.45 kg/cm^2	6.0 kg/cm^2
Flexor Hallucis Brevis Left (test 3)	2.5 kg/cm^2	5.8 kg/cm^2
Flexor Hallucis Brevis Right (test 1)	4.2 kg/cm^2	5.8 kg/cm^2
Flexor Hallucis Brevis Right (test 2)	4.3 kg/cm^2	6.5 kg/cm^2
Flexor Hallucis Brevis Right (test 3)	4.5 kg/cm^2	6.4 kg/cm^2

(b)

Wind-Up Ratio (a key QST metric that quantifies TSP)

Left Heel (S1, S2 Tibial n.)			Right Heel (S1, S2 Tibial n.)			Left Plantar 5th Metatarsal (S1, S2 L. Plantar n.)			Right Plantar 5th Metatarsal (S1, S2 L. Plantar n.)		
	Pre-Tx	Post-Tx		Pre-Tx	Post-Tx		Pre-Tx	Post-Tx		Pre-Tx	Post-Tx
Test 1	1	1	Test 1	1	1	Test 1	2	1	Test 1	1	1
Test 2	1	1	Test 2	1	1	Test 2	2	1	Test 2	1	1
Test 3	1	1	Test 3	1	1	Test 3	2	1	Test 3	1	1
Test 4	1	1	Test 4	1	1	Test 4	3	1	Test 4	1	1
Test 5	1	1	Test 5	1	1	Test 5	3	1	Test 5	1	1
Test 6	1	1	Test 6	1	1	Test 6	3	2	Test 6	1	1
Test 7	1	1	Test 7	1	1	Test 7	3	2	Test 7	2	1
Test 8	1	1	Test 8	1	1	Test 8	3	1	Test 8	1	1
Test 9	1	1	Test 9	1	1	Test 9	3	1	Test 9	1	1
Test 10	2	1	Test 10	1	1	Test 10	3	1	Test 10	1	1
TSP Sum Score	13	10		10	10		75	16		13	10

Pressure pain threshold (PPT) measurements (a) of the involved (left) lower extremity S1 and S2 myotomes increased from a mean of 2.4 kg/cm^2 pre-treatment to 6.1 kg/cm^2 post-treatment. Temporal summation of pain (TSP) sum scores (b) for the S1 and S2 dermatomes decreased from 75/10 pre-treatment to 18/10 post-treatment (76% reduction), meeting the threshold for clinically meaningful pain relief as defined by Baeumler et al. (2019) [23].

2.2. Clinician-Assessed Outcomes

The observed elevation in wind-up within the left lateral plantar nerve distribution (S1–S2 dermatomes on TSP testing) aligned with the clinical FCS diagnosis of S1–S2 radiculitis. We then applied a TSP sum score outcome measure to quantify the total wind-up across the train of 10 stimuli, as previously published [21]. Results demonstrated the normalization of all post-treatment wind-up scores, except for the left S1 and S2 dermatomes, which failed to fully normalize; however, they did improve by 76%, from a sum score of 75/10 to 18/10 [29]. The results lend support to the validity of the FCS diagnostic process through its alignment with pre-treatment TSP indicators of central sensitization and by exceeding the study's > 50% threshold for diagnostic validity and clinically meaningful pain relief as established by Baeumler et al. [23].

Baseline PPT measurements obtained over the bilateral flexor hallucis brevis muscles (S1 and S2 myotomes) demonstrated pre-treatment thresholds to be 2.4 kg/cm^2 left and 4.3 kg/cm^2 right. Following treatment, muscle sensitivity decreased substantially to a pressure tolerance of 6.1 kg/cm^2 left and 6.2 kg/cm^2 right. These post-intervention PPT increases of 3.7 kg/cm^2 (left) and 1.9 kg/cm^2 (right) also exceed the previously defined

minimum detectable change threshold of >1.5 kg/cm^2 for clinical efficacy and meaningful post-treatment hypoalgesia.

Reduced pre-treatment PPTs on the patient's right (asymptomatic) side suggested some degree of bilateral S1 and S2 central sensitization. As documented in Table 1, right-sided muscle sensitivity was also reduced post-treatment, as all treatment techniques were performed bilaterally, as indicated by the FCS diagnostic process.

2.3. Patient Perspective Statement

Patient correspondence at six weeks post-treatment (via text message) subjectively confirmed the above improvements, which are described in the following *patient perspective statement*:

> "After one session of treatment, I felt the tightness in my lower back which extended to my hamstrings reduced tremendously. The pain was certainly more manageable, and I could perform my usual activities without having to take breaks, and though it was only one session, there has been lasting improvement for me."

2.4. Changes in Therapeutic Intervention

This study's intent was to assess FCS's diagnostic validity and immediate post-treatment effects using QST, without intervention changes or comparisons to other therapies. Randomized controlled trials are needed to evaluate relative efficacy and long-term outcomes.

2.5. Adverse Reactions and/or Events

There were no adverse reactions reported during or after the singular FCS treatment.

3. Follow-Up Diagnostic Tests and/or Results

As a single-session case report employing QST, this study assessed only the immediate post-treatment effect of FCS; therefore, no follow-up evaluations were conducted leaving long-term therapeutic outcomes unquantified.

4. Conclusions and Case Report "Take-Away"

The strength of this case report is that it utilized immediate, post-treatment QST measurements to evaluate treatment outcomes, removing the possibility of symptom reduction over time.

The exploratory nature of this investigation is limited by the inherent constraints of the case study design, including the absence of a placebo-controlled treatment, longitudinal quantitative outcome measurements, and the inability of case studies to be generalized to broader patient populations. To substantiate these preliminary findings, future research should include adequately powered randomized controlled trials across a diverse range of musculoskeletal and non-musculoskeletal conditions (>30 participants per group) to achieve sufficient statistical power.

The "take-away" from this case report is that it represents the first quantitative study providing preliminary evidence for both the diagnostic accuracy and immediate therapeutic efficacy of FCS. The results demonstrate substantial post-treatment improvements in TSP wind-up sum scores and PPTs (within the predicted S1–S2 segmental distributions), supporting both processes. Considering FCS's non-pharmacological and non-invasive nature, it may offer a promising treatment option for chronic idiopathic musculoskeletal, lymphatic, visceral, and vascular conditions.

Author Contributions: Conceptualization, B.T., J.S. (Jay Shah), and J.S. (John Srbely); methodology, B.T., J.S. (Jay Shah), and J.S. (John Srbely); formal analysis, J.S. (Jay Shah); investigation, B.T., J.S. (Jay Shah), and J.S. (John Srbely); resources, J.S. (Jay Shah) provided QST and PPT equipment and performed the pre- and post-treatment measurements and data curation; writing of the original draft, B.T.; reviewing and editing, B.T., J.S. (Jay Shah), and J.S. (John Srbely); visualization, B.T. and J.S. (Jay Shah); supervision, J.S. (John Srbely); project administration, J.S. (John Srbely). All authors have read and agreed to the published version of the manuscript.

Funding: This research received no external funding.

Institutional Review Board Statement: Ethical approval was waived for this report because it describes a single clinical case and was not designed or conducted as a systematic research project and therefore does not meet the regulatory definition of human-subjects research.

Informed Consent Statement: Written informed consent was obtained from the participating patient to publish this paper.

Data Availability Statement: The original contributions presented in this study are included in the article material. Further inquiries can be directed to the corresponding authors.

Acknowledgments: We are grateful to Kristin Murner for her assistance and expertise with the manuscript preparation and submission process.

Conflicts of Interest: Author, Brian Tuckey PT, OCS is the developer of Fascial Counterstrain and teaches FCS internationally through several different intermediary companies including the Jones Institute in the United States. The remaining authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

Abbreviations

The following abbreviations are used in this manuscript:

QST	Quantitative Sensory Testing
PPT	Pain Pressure Threshold
TSP	Temporal Summation of Pain
FCS	Fascial Counterstrain
TPs	Tender Points

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