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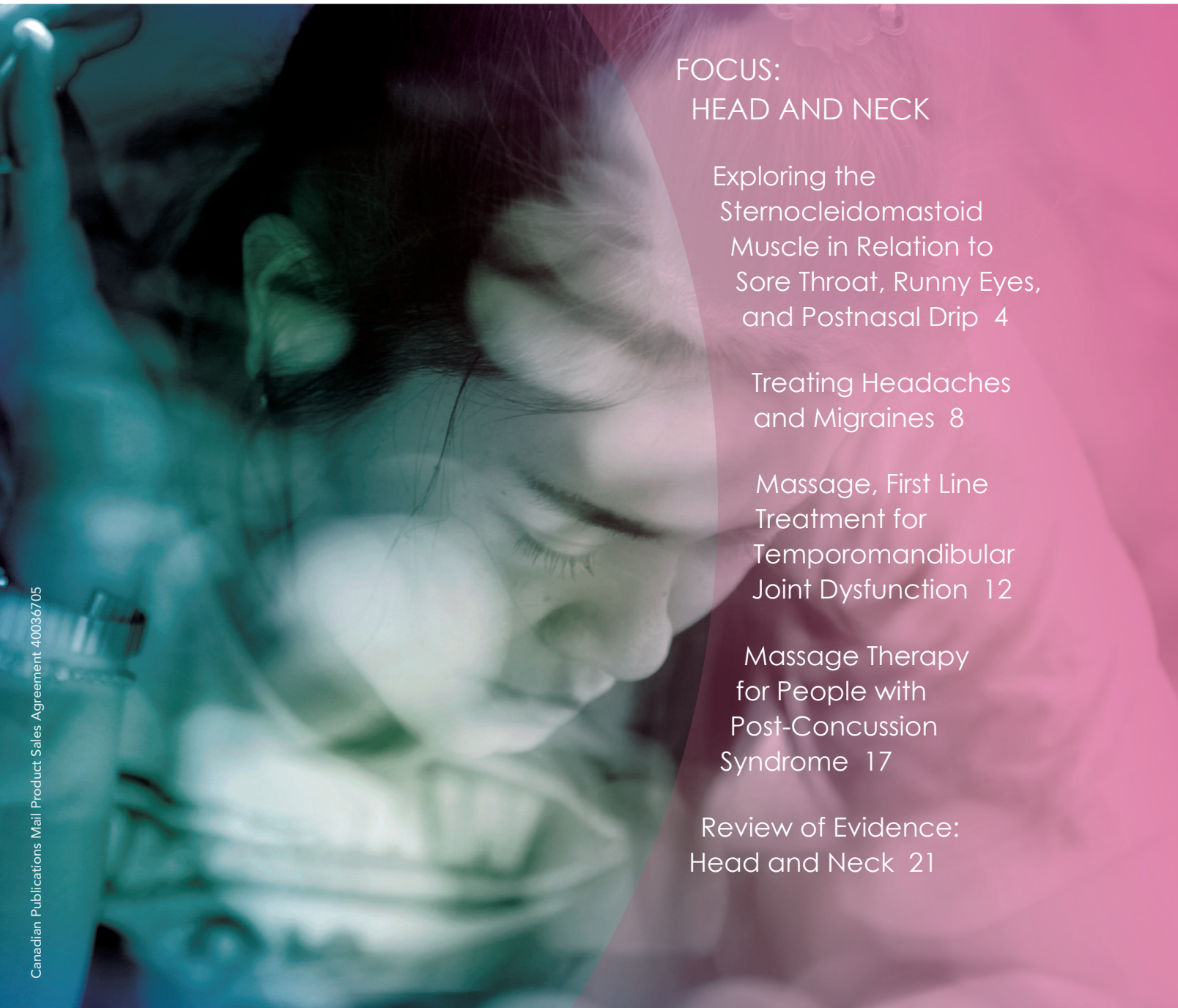

FOCUS:
HEAD AND NECK

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Exploring the Sternocleidomastoid Muscle in Relation to Sore Throat, Runny Eyes, and Postnasal Drip

By Anne Käärid, RMT, NHP

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Headlines warning of new COVID-19 variants and the onslaught of viruses that usually cause cold-like symptoms have made many of us hyperaware of the germs that make us sick. But how often are we considering that some of these "symptoms" may stem from tight muscles—and not a long-lasting virus at all?

In this article, I will explore the dysfunction of the sternocleidomastoid (SCM) muscle. As RMTs, we are aware that imbalance in this structure can result in head and face pain, nausea, and dizziness—but it may also cause coryza, lacrimation, and even muscle tension dysphagia. I would like to share with you an experience I had with a patient that experienced imbalance in this often-overlooked area, and how trigger points and SCM dysfunction came into play in his presentation and restoration.

Case study

The patient presented with complaints of posterior shoulder and lateral neck pain. He expressed that this was his "normal" because of his job (computer work and driving) and because he played hard at seasonal golf and hockey. Through our intake and assessments, he shared that he experienced occasional facial numbness and tingling over his right forehead, ear, and cheek, which sometimes caused his eyelid to twitch excessively and produce a flow of tears. Exploring this further, he shared that he had been to several doctors over the past 16 months because of chronic pain in his throat. His pain was about 8 on the pain scale at its worst and remained around a 3 day-to-day. He had been concerned about cancer, but all tests by his physician (such as swabs, bloodwork, and a physical exam) and imaging done to that point had shown everything to be normal. He was scheduled for an MRI a few months down the road. He had no previous history of accidents or blunt force trauma that could be linked with the onset of these symptoms.

Assessments

During posture analysis, I observed decreased cervical lordosis, forward head posture, and bilateral internal rotation of his shoulders. It was evident that he had biomechanically flawed posture when testing range of motion (ROM): his cervical ROM was slightly compensated in rotation and flexion with some discomfort in rotation and extension. Other ROM, myotome, and dermatome tests all fell into the normal range. The patient also exhibited faulty breathing patterns by overuse of the scalene group and SCM muscles. Proprioceptive testing indicated some challenges in his sense of balance. Orthopedic tests showed weakness in deep neck flexors and the lower and middle trapezius muscles.

Deep tissue palpation revealed the presence of the following:

Multiple trigger points in the upper trapezius and levator scapulae muscles bilaterally, referring pain to the suboccipital area. Two bundles of trigger points in the right clavicular head of the SCM, referring pain to the cheek

and sinus areas and recreating significant pain in the throat, especially when swallowing.

My findings showed that the patient had developed multiple postural compensations, including altered neck flexion due to tightness in the SCM, scalenes, upper trapezius, and levator scapulae. After this series of assessments, my patient shared with me how surprised he was that so much of his pain could be recreated by such a small area of his neck. But he was excited to shed some light on the situation, and was open to trying treatment for this sensitive area.

Treatment

The goals of treatment were to relax and elongate the shortened muscles, to strengthen the weak muscles, and re-educate the patient on breathing patterns through diaphragmatic breathing. Shallow or inefficient breathing negatively impacts the proper movement of the sternum, clavicles, ribs, and diaphragm, and this is important in relation to the SCM and scalenes. As we know, the SCM attaches to the sternum, and the scalenes attach to the first and second ribs and act as accessory muscles to inhalation. Diaphragmatic breathing inhibits the involvement of overactive accessory muscles by keeping their activity to a minimum and allowing free and proper movement of the muscles of respiration, sternum, clavicle, ribs, and diaphragm. These multiple goals were incorporated into a treatment plan that included a series of passive and active treatments targeting not only the SCM and scalenes, but also a hypertonic masseter and temporalis, where latent trigger points were found that referred pain into the cheek and upper teeth. Treatment included a varied approach of manual soft tissue techniques, post isometric relaxation (PIR), and intentional breathwork. The work on the SCM was slow and intentional, and it produced a lot of coughing from the patient, so I kept a glass of water on hand for him. Communication between us was key to gauge where he was on the pain scale and ensure that the treatment was not causing nausea. I focused on the tone of the trigger points to make sure the bundle did not tighten back up under my fingers and reverse the work we had done. Of course, the areas were well flushed with gentle and directional effleurage to encourage the muscle fibers to return to their healthy state. Slow ROM stretching of the SCM was an essential part of each treatment, along with guided breathwork and the application of heat to the area. My patient appreciated this after a hard "work-out" on his neck.

Conclusion

The patient was instructed on some general at-home care and remedial exercises, and he was advised to continue with a regular breathwork practice. I encouraged him to keep me updated on any reactions to treatment, especially in the beginning stages of the plan. We also discussed reaching out to other allied health practitioners (i.e., an osteopath, postural therapist, physical therapist, or personal trainer) to include them in his circle of care to further his recovery. He was very open and grateful for this suggestion and took the journey to healing seriously. He began to see a personal trainer and an osteopath to prevent further aggravation of the region. My patient was extremely happy to regain some control over his pain (through treatment, exercise, posture, and breathing exercises) and responded to treatment rather quickly. He maintains a regular schedule with massage and his osteopath and exercises and stretches regularly. He is thankful that he

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has not experienced any throat or swallowing pain, facial numbness, or eye twitching with lacrimation since.

Although the outcomes in this case were very successful, I need to be clear that no diagnosis was offered or implied when working with this patient. He understood the scope of the massage practice and what to expect of the treatment plan. However, he stated his appreciation for the time that I took to assess him and what those assessments revealed. Furthermore, he was grateful for the discussion of options for complementary treatments from other health care providers that could be helpful. Encouraging him to include other practitioners in his circle of care meant that the appropriate professionals were able to make diagnoses (within their scope of practice) and reveal the root of his issues. This resulted in a multi-faceted and collaborative treatment plan to bring his structures to balance and help him continue with healthy choices for his self-care.

This experience made me realize that the throat referral may be a commonly overlooked cause of chronic sore throat. The complaint often is of something stuck in the throat, or a feeling of fullness in the throat, especially when swallowing. It may be mistaken for pharyngitis. As we know, a common pain referral pattern of the SCM includes pain over the cheekbone, in the forehead, on top of the head, and in and behind the ear. However, it also can provoke pain or loss of sensation over the chin, over the sternoclavicular joint, and deep in the throat. When I further studied the clavicular division of the SCM, I learned that the forehead referral pattern is perhaps the only one that can cross the midline. Additionally, trigger points may cause symptoms of vertigo, syncope, nausea, ataxia, and dysmetria, and even disequilibrium symptoms. Of course, symptoms must be differentially diagnosed by a physician, as this is out of our scope of practice. But awareness of these symptoms gives us some insight and indication to further investigate when assessing, treating, and discussing our patients’ treatment options.

As you probably already know, treating the trigger points in the SCM can be daunting, since so many underlying factors may be involved. When assessing the patient, I encourage you to look for joint dysfunction in the upper cervical spine, sternoclavicular joint, and the temporomandibular joint. Be sure to also consider the patient’s static posture and movement patterns, especially cervical flexion, swallowing, and sit-to-stand movement (for balance and upper body or cervical spine posture). These will provide important clues when forming your treatment plan. It is best that the patient is treated in the supine position in order to ensure that the muscle will be completely relaxed. I found that ischemic compression, pin and stretch, and isometric relaxation are quite effective. Be sure to check in with your patient often during treatment and be prepared for some possibly profound outcomes.

Unfortunately, the fact that my patient’s symptoms could be elicited from trigger points in the SCM was not diagnostically considered by any of the health care practitioners who previously examined him. The massage therapy approach, combined with appropriate collaborative care, proved to be a highly valuable asset in finding the correct treatment for him. This case testifies to the indispensable role massage therapists can play in collaborative multidisciplinary treatment plans, perhaps by offering not only a different approach, but also a constructive point of view. MT

References available upon request.