

TERES MAJOR SYNDROME

The *Teres Major Syndrome* takes its name from the fact that its distinctive DSR zone overlies the teres major muscle, as illustrated below.

The patient who suffers from *Teres Major Syndrome* predictably complains of a diffuse pain that may overlie the infraspinatus, upper trapezius, posterior deltoid, and triceps areas. The pain may seem to have a neurological flavor by being either a burning sensation or a feeling of “tingling and numbness” in the affected areas.

Notably, the *Teres Major Syndrome* is often found to complicate and accompany the *Radial Trunk, Radial Channel, Ulnar Channel, Extensor Tunnel, or Carpal Tunnel Syndromes* (or any combination of them). It seems to adversely affect the capillary circulation in the involved posterior shoulder and arm areas, to the extent that more distal syndromes may develop as a result of the mild ischemia, so in effect it may be “causal”. Indeed, until the *Teres Major Syndrome* has been successfully treated the more distal syndromes will continue as problems (this syndrome was originally discovered as the result of a general DSR survey conducted to establish why a bilateral elbow pain problem would not respond to therapy). However, once the *teres major syndrome* has been successfully treated, the more distal syndromes will almost simultaneously disappear. Why an inflammation over the teres major should adversely affect either the neurological or vascular elements, in the affected shoulder and arm areas is unclear and, as yet, unexplained.



The high skin resistance pattern commonly associated with inflammation of the Teres Major Syndrome

Treatment

A relatively large adhesion formation, often resembling a sub dermal scar mass, lying over the teres major, is almost always found to be present in the *teres major syndrome*, but overt swelling in the area, even to a small extent, is exceedingly rare. Treatment must be directed at eliminating the associated inflammation and adhesions.

Application:

- Place a negative electrode over the teres major muscle and a positive electrode over the upper trapezius muscle on the involved side (if no other syndrome is present). Preset an electrical stimulation unit to deliver a visible contraction, at 7 Hz. Stimulate for 10 minutes.
- Then set the unit to deliver a medium frequency current, with a duty cycle of 10-seconds on and 10-seconds off. Adjust the amplitude to a level sufficient to produce a near tetanic contraction of the involved muscles. Stimulate for 10 minutes.
- Manipulate the soft tissues lying over the teres major muscle to eliminate any adhesions that may be present. Manipulation of this area is predictably very painful for the patient.
- Preset the ultrasound unit to deliver a 1 MHz pulsed waveform, at 1.8 W/cm². Ultrasound the inflamed zone, utilizing an effective non-steroidal anti-inflammatory as a coupling agent, for six minutes.

The following treatment forms have also been effective.

Variation:

- Preset the ultrasound unit to deliver a 1 MHz pulsed waveform, at 1.8 W/cm². Ultrasound the inflamed zone, utilizing an effective non-steroidal anti-inflammatory as a coupling agent, for six minutes. This procedure is designed to soften the adhesions that may be present.
- Manipulate the tissues in and around the inflamed zone to eliminate any adhesions that may be present.
- Twenty minutes after the first ultrasound, preset the ultrasound unit to deliver a 1 MHz pulsed waveform, at 1.5 W/cm². Ultrasound the inflamed zone, utilizing an effective non-steroidal anti-inflammatory as a coupling agent, for six minutes. This is performed to “cool off” the manipulated zone by effectively halting the production of prostaglandins by the stressed tissues.
- Apply mechanical vibration, delivered at 60 to 120 Hz, over the inflamed zone, for two minutes. Apply the vibration at a relatively high but tolerably comfortable level for the patient. This is performed to increase capillary circulation in the involved tissues.

Variation:

- Preset the ultrasound unit to deliver a 1 MHz pulsed waveform, at 1.8 W/cm². Ultrasound the inflamed zone, utilizing an effective non-steroidal anti-inflammatory as a coupling agent, for six minutes. This procedure is designed to soften the adhesions that may be present.
- Manipulate the tissues in and around the inflamed zone to eliminate any adhesions that may be present.

- Apply cold laser (with or without simultaneous electrical stimulation provided by the laser applicator) to the inflamed zone for approximately 6 minutes. This is performed to “cool off” the manipulated zone by effectively halting the production of prostaglandins (or facilitating enzyme destruction of **all** inflammatory being produced) by the stressed tissues.
- Apply mechanical vibration, delivered at 60 to 120 Hz, over the inflamed zone, for two minutes. Apply the vibration at a relatively high but tolerably comfortable level for the patient. This is performed to increase capillary circulation in the involved tissues.

Typically, adequate treatment should effect relief from the *Teres Major Syndrome* in one or two treatments, barring other complications.

Trigger Points

The following trigger point formations may, singly or in combination, imitate or contribute to the pain accompanying a *Teres Major Syndrome*: Scalenus, Scalenus (minimus), Infraspinatus, Medial teres major, Lateral teres major, Teres minor, Coracobrachialis, Supraspinatus (muscle), Supraspinatus (tendon), Latissimus dorsi (upper portion), Serratus posterior superior, Serratus anterior, Subclavius, Subscapularis, Posterior deltoid, Pectoralis major (sternal portion), Pectoralis minor, Sternalis, Medial triceps (deep fibers), Triceps (long head), Distal medial triceps, Anconeus, Extensor carpi radialis longus, and Fourth finger extensor.