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The common theme of this three part series relates to how gall bladder dysfunction and disease progressively places a drag upon general physiology by impeding venous and lymphatic return. First, I will describe the various somatic markers that I have experienced with clients associated with the progression of gall bladder dysfunction or disease via the inflammatory process. Next, I will postulate how gall bladder dysfunction may functionally affect the rest of the digestive tract and blood sugar regulation. Further, I will describe how gall bladder difficulties may participate in many hiatal hernia reflux problems, esophageal problems, chronic headache patterns and the existential questions of life.

The purpose of these descriptions is to add to your library one of the more common progressions that I have encountered when working with clients who state that they have a chronic problem or pain that “just won’t go away” even after care from other competent professionals. Their typical somatic complaints will include the persistence of one or more of the following: their right shoulder & upper back with or, without radicular symptoms (pain or numbness into the shoulder, elbow, arm or hand), neck pain and headaches, including migraines and interestingly, left hip problems.

Additional markers which indicate involvement of the gall bladder include: pain or limited motion of the left side of the neck (1), progressive loss in the range of motion in or, freezing of the right shoulder, recurrent upper to middle right sided rib subluxations with accompanying muscle contracture or spasm, reduction in the ease of lateral excursion of the right hemi-diaphragm, hiatal hernia complaints, a marked reduction of ease in spinal flexion and extension during motion testing, and a history of external hemorrhoids. Rarely, are all of these reported or can be identified in an initial interview and session with a client. Yet, over time, they do begin to reveal themselves.

I have selected this progression because it tends to fly under the radar of medical testing, often for years, until its dysfunction becomes acute. I would hasten to add that if one has trouble with their gall bladder that the normal function of their liver is questionable. It is beyond the scope of this article to explore the influence of both organs simultaneously yet, the inflammatory response of the liver produces almost identical somatic profiles.

It has been my consistent clinical experience that gall bladder dysfunction tends to precede the identification of chronic liver dysfunction thus, it becomes another example of how the body uses an ailment as the “canary in the coal mine” to signal us that something deeper is amiss. Following the removal of the gall bladder, some clients have received a diagnosis of moderate to severe liver dysfunction including Cirrhosis, or Non-Alcoholic Fatty Liver Disease many years later. This is the nature of progressions.

One of the principles of the Inside-Out Paradigm© is to seek to comprehend how the body is organized to move and re-cycle its fluids back to the heart and lungs especially, the low pressure systems of lymphatic and venous return. Whatever may impede this flow can progressively create the breeding ground for various pathologies to begin. In the interim, a

client's quality of life is insidiously diminished. Our role in therapeutic touch is to enhance their quality of life and to serve as part of their early detection team.

The following description is anecdotal and represents extrapolations of functional physiology (how one thing may relate to another) that are based on my clinical experience. Please, do not consider these ideas to be proven fact.

I propose that varying degrees of gall bladder dysfunction is an unidentified variable in many somatic profiles because of its "anatomic centrality". In normal anatomic position, which can vary, it sits; just adjacent, to the inferior vena cava, in fascial communication with the portal vein of the liver, just anterior to the transverse colon and in approximation to the abdominal confluence of lymph trunks, often referred to as the cisterna chyli (2).

Inflammation of the gall bladder in response to neural excitation or gall stone formation can literally decrease the "rate of flow" of the fluids within the low pressure venous & lymphatic vessels. When inflamed, the gall bladder swells to occupy more space thus pushing on these more flexible tubes and a "pinched hose effect" is created. The reduction of the timely return of these fluids back to the heart and lungs places an accretive strain upon the many tasks of maintaining physiologic homeostasis and upon a client's perception of life and themselves.

The most common error any practitioner makes is to predict that emotional factors are the primary source or, that physical factors are the primary source of a chronic problem. In my experience, both represent slices of the pie that may contribute to resolving the chronic problems of clients.

According to Dr. Barral, the developer of Visceral Manipulation, the gall bladder tends to be the most reactive organ outside of the brain and spinal cord to emotionally charged events. For example, receiving the news that a loved one has died, witnessing an accident, or being unexpectedly fired from one's employment are among many possible triggering events (1).

"Sympathetic innervation of the gall bladder is from the celiac ganglion, and innervation from its peritoneal surface from the phrenic nerve. Contraction of smooth muscle within its walls depends on the vagus nerve, i.e., biliary excretion is under parasympathetic control" (3). In my articles on the Phrenic Circuit, I endeavored to set a foundation for how the body distributes these internal tensions through its complex neural net and specifically within the shared cervical portions of the spinal cord which overlap the origins of both the phrenic nerves and the brachial plexuses(4). The latter being the vitalizing source for the shoulders & upper extremities.

It is the presence of chronic inflammation that we need to hold clear in our field of awareness. Its presence is inferred by the persistence of the somatic complaints detailed earlier. I have personally worked with people for many years until the underlying source(s) of their somatic complaints emerged. This is how I may offer a description of this progression to you. Acute inflammation of the gall bladder and/or the passage of a gallstone stuck in the common bile duct usually requires some medical attention.

It is prudent for us to refer clients to their physicians when we suspect such a chronic problem and/or when our best efforts fail. Usually blood tests and an ultrasound scan are ordered to

check for the presence of gallstones and any possible infection. Quite often, if there are no stones, the notion that the gall bladder is a relevant variable is dismissed. There is a second test called the Function Test to check if the gall bladder is actually working at all. It is important for to educate our clients that this is an option. The test is not a pleasant experience as one is asked to swallow a liquid that places a demand upon the gall bladder while its capacity to function is being monitored. If it no longer is functioning, the possibility of infection or other pathologies developing increases. In one such instance the client's gall bladder was diagnosed as pre-cancerous.

Gallstones are made up of calcium bile salts and cholesterol. The actual process of how and why they are formed elicits many possible opinions with little definitive conclusions. The statistics detailed in Dr. Barral's second book, *Visceral Manipulation II*, note that within the US, 8% of men and 20% of women over the age of 40 are affected by gall stones and that 2 million surgical procedures are performed every year to remove the gall bladder (3). Not all gallstones produce adverse symptoms paradoxically. Larger gallstones unable to exit the gall bladder may lie passively dormant for years. However, to my sensibilities they contribute to the organ's chronic inflammation and do have an effect upon venous & lymphatic drainage.

When initially interviewing a client take note of whether their parents, grandparents, or siblings have had such difficulties. Of all the somatic markers noted earlier, the progressive stiffening of the spine exhibited by a reduction of ease to flexion & extension during motion testing is an indication that the chronic problem is progressively affecting the client. I have seen this repeatedly.

I cited the case study of a client in an earlier article who had experienced the freezing of his right shoulder. All of my attempts to assist its re-mobilization failed. I encouraged him to see his physician and two large gallstones were found. Though encouraged by his physician to have them removed, he declined. Now, many years later, he is struggling with rectal cancer.

The inference here is not, to be taken as cause & effect. However, when fluids of the body are unable to find their way to all of its cells and/or its fluids are impeded from returning to the heart and lungs in a timely manner, it is my postulation that this does set the stage for many possible pathologies to emerge.

The main idea for your consideration is that gall bladder dysfunction and disease may progress in insidious and subtle ways. It is our responsibility to be alert to its possible presence and progression. For all of us, let us be aware that eating large quantities of fried, processed, heavily spicy, or greasy foods may contribute to gall bladder dysfunction.

In the second installment of this article I will describe what I speculate often happens when bile sludge or small gall stones partially or, fully occlude the opening through which both bile and pancreatic juices flow into the duodenal portion of the small intestine, its ramifications for digestion and elimination and its simultaneous role of reducing venous and lymphatic drainage and their timely return to the heart.

References:

1. Dr. Jean-Pierre Barral, developer of Visceral Manipulation, class notes, 1987 – 1993.
2. Gray's Anatomy / pgs. 1393-96, Williams, Warwick, Dyson, and Bannister, Churchill Livingstone, 1989
3. Visceral Manipulation II, Dr. Jean-Pierre Barral, Eastland Press, 1989.
4. The Phrenic Circuit, Dale G. Alexander Ph.D. L.M.T. Massage Today, June 2006, Vol. 06, Issue 06 and The Phrenic Circuit / Part II, Massage Today, Dec. 2006, Vol. 6, Issue 12.