International Journal for Multidisciplinary Research (IJFMR)
E-ISSN: 2582-2160 ● Website: www.ijfmr.com ● Email: editor@ijfmr.com

A Literature Review on Effectiveness of Muscle Release Techniques on Periarthritis Shoulder Among Various Population

Tushar Rajesh Sutar[1], R. Sedhunivas[2], Arnold Nikhilesh[3]

[1]Post Graduate Student, M.P.T. Musculoskeletal Sciences, Garden City University, Bangalore, India
[2,3]Assistant Professor, Department Of Physiotherapy, Garden City University, Bangalore, India.

Abstract

Objective: To explore the effectiveness of various muscle release techniques on periarthritis shoulder.

Methods: Searches were conducted in Google Scholar, PubMed, etc. A literature review was conducted of only randomized controlled trials that reported extractable data relevant to the study. The search included all studies upto 2015 to 2025. Out of many articles only total of 21 randomized control trial studies were included.

Results: After the segregation process, a total of ten randomized controlled trials (RCT) Articles were identified and presented in tabular form. The search process and selection criteria are illustrated in the accompanying flowchart.

Conclusion: Based on the reviewed studies, the most effective muscle release techniques, including myofascial release, trigger point therapy, and Cyriax release, have demonstrated significant effectiveness in managing periarthritis shoulder by reducing pain and improving shoulder range of motion (ROM) and functional capacity.

Keywords: Periarthritis shoulder, myofascial release, trigger point therapy, and Cyriax release

INTRODUCTION

Periarthritis of the shoulder, commonly known as frozen shoulder or adhesive capsulitis, is a debilitating condition characterised by pain, stiffness, and progressive loss of shoulder joint mobility. This musculoskeletal disorder significantly impairs daily function and quality of life due to the restriction of active and passive movements of the shoulder, particularly affecting abduction, external rotation, and flexion. Muscle release techniques have emerged as vital interventions in managing this condition, aiming to alleviate pain, restore range of motion, and improve functional capacity.

Stages of Periarthritis Shoulder

Periarthritis shoulder progresses through distinct clinical stages that overlap and vary in duration among individuals. Understanding these phases is essential for targeted treatment, including muscle release therapies.

1. **Freezing (Painful) Stage:** This initial stage typically lasts between 2 to 6 months and is characterized by gradual onset of moderate to severe shoulder pain, especially at night and with movement. Partial loss of range of motion (ROM) begins during this stage due to pain-induced guarding. Histologically, this corresponds to synovial inflammation and hyperplasia without

significant capsular fibrosis.[1,2]

2. **Frozen (Adhesive or Stiffening) Stage:** Lasting approximately 4 to 12 months, this stage features reduced pain but prominent stiffness and marked loss of both active and passive ROM. Pathologically, it is dominated by capsular thickening, fibrosis, and contracture producing severe functional limitation. The predominant complaint shifts from pain to restricted movement.[1]
3. **Thawing (Resolution) Stage:** This stage spans 6 to 24 months or longer, during which pain progressively resolves and shoulder motion gradually improves. The capsular fibrosis remodels, and muscle function begins to restore. Rehabilitation techniques, including muscle release procedures, assist in regaining function during this phase.[5]

Adhesive capsulitis, or frozen shoulder, is characterised by inflammation, fibrosis, and contracture of the shoulder joint capsule, leading to pain and progressive loss of motion. The condition can be classified into primary (idiopathic) and secondary types, with the primary form often linked to systemic conditions such as diabetes mellitus and thyroid disorders, suggesting a possible autoimmune or systemic inflammatory basis. Secondary adhesive capsulitis develops after an external event such as trauma, surgery, or prolonged immobilization, which causes joint capsule inflammation and subsequent fibrosis. The pathophysiology involves an initial inflammatory phase where synovial inflammation occurs, followed by deposition of excess collagen leading to thickening and contraction of the joint capsule, especially in the rotator interval and coracohumeral ligament, reducing joint volume and mobility. This process is mediated by fibroblast proliferation and cytokine activity, resulting in dense scar tissue (adhesions) and joint stiffness. Microvascular complications in conditions like diabetes may impair collagen repair and exacerbate fibrosis, increasing susceptibility to adhesive capsulitis. The condition progresses through phases starting with painful freezing, followed by stiffness (frozen phase), and eventually a thawing phase where motion gradually returns. These pathological and systemic factors collectively cause the significant pain, stiffness, and functional limitation characteristic of adhesive capsulitis.[5,6]

The prevalence of adhesive capsulitis varies across different populations and studies, but is generally estimated to affect approximately 2% to 5% of the general population. It is most commonly seen in middle-aged adults, particularly between the ages of 40 and 60 years, with a higher incidence reported in women. Certain groups, such as patients with diabetes mellitus, have shown a markedly higher prevalence, with some studies reporting up to 38% prevalence among diabetics, especially in females. The condition's prevalence in older adults, particularly those over 65 years, is lower but still significant, with estimates around 0.35% to 2.4% for one-year and lifetime prevalence. Overall, adhesive capsulitis is a common shoulder disorder, especially impacting middle-aged women and individuals with comorbid systemic conditions like diabetes and thyroid disease. These statistics highlight the importance of awareness and early diagnosis in at-risk populations to better manage this disabling condition.

The clinical features of adhesive capsulitis, or frozen shoulder, primarily include pain, stiffness, and functional impairment of the affected shoulder. Patients typically describe a deep, dull ache that may radiate into the biceps, and this pain often worsens at night, disrupting sleep. Along with pain, there is a prominent decrease in both active and passive range of motion, affecting movements such as flexion, abduction, external rotation, and internal rotation. This restriction in mobility is usually bilateral but more pronounced on the affected side and progresses gradually over weeks to months.[9,10]

Clinically, the condition involves three stages: an initial painful or "freezing" stage, a frozen stage

characterized by persistent stiffness with less pain, and a thawing phase where shoulder motion gradually improves. During the frozen stage, patients exhibit marked capsular tightness, muscular atrophy, and tenderness on palpation, although focal tenderness is uncommon, which helps distinguish it from other shoulder pathologies . Sometimes, a loss of arm swing during gait and muscle atrophy can be observed in advanced cases. Imaging studies, such as MRI, may show thickening of the joint capsule and coracohumeral ligament, supporting the diagnosis but are often not required for clinical confirmation. Overall, the hallmark signs include significant pain, shoulder stiffness, and the inability to perform movements that were previously easy, affecting daily and functional activities.[4,12]

Surgical treatment of adhesive capsulitis is generally considered when conservative therapies, such as physical therapy and injections, fail to improve symptoms after several months. The two most common surgical approaches are manipulation under anesthesia (MUA) and arthroscopic capsular release (CR). In MUA, the patient is placed under general anesthesia, and the surgeon forcibly moves the shoulder through its range of motion to stretch or tear the contracted joint capsule and scar tissue, thereby increasing mobility. Arthroscopic capsular release involves introducing a small camera and instruments through tiny incisions around the shoulder to surgically cut the tight and thickened portions of the capsule, including the rotator interval, anterior, posterior, and inferior capsule. This technique allows more controlled and precise release of adhesions while also addressing any intra-articular or subacromial pathology. Both procedures are followed by early initiation of physical therapy to maintain the gained range of motion, emphasizing passive and active stretching progressing to strengthening exercises. Studies show that MUA often results in greater improvement in external rotation postoperatively, but both MUA and arthroscopic capsular release are effective in improving overall shoulder range of motion and reducing pain. Surgical decision-making may depend on patient factors such as age, severity, comorbidities like diabetes, and surgeon preference. Despite the effectiveness of these surgeries, there is still no clear consensus on which technique is superior, and risks such as fracture or nerve injury can occur, although they are rare. Overall, surgical treatment aims to restore shoulder function by releasing capsular contraction and allowing improved joint mobility in patients with refractory adhesive capsulitis.[13,15]

Muscle release, particularly myofascial release, is a manual therapy technique used to treat adhesive capsulitis by targeting muscle tightness and trigger points that contribute to pain and restricted motion. This method involves applying sustained pressure to the muscles and fascia around the shoulder, particularly on areas that are tender or stiff, to relieve muscle spasms, improve blood flow, and restore normal muscle length and flexibility. The treatment often focuses on muscles involved in shoulder movement, such as the subscapularis, pectoralis major, levator scapulae, and trapezius. Studies have shown that muscle release techniques contribute to increased pressure pain threshold, enhanced muscle flexibility, and improved shoulder range of motion in patients with frozen shoulder. The technique is typically administered by a physical therapist who applies deep, targeted pressure using fingers or elbows for 60 to 90 seconds or until muscle tension decreases and pain relief is perceived by the patient. Combining muscle release with conventional therapy, such as stretching and mobilization provides a synergistic effect to improve clinical outcomes, reduce pain, and accelerate functional recovery. Muscle release therapy addresses the myofascial components of adhesive capsulitis, helping to loosen restricted muscles and fascia that limit shoulder motion and contribute to discomfort.[7,11]

NEED OF THE STUDY

The need for this study stems from the high prevalence and significant functional impact of periarthritis shoulder, commonly known as frozen shoulder, which affects 2-5% of the general population and is even more common in individuals with diabetes and thyroid disorders. This study addresses this critical gap by systematically comparing the Effectiveness of Muscle Release on Periarthritis Shoulder. The findings are expected to inform evidence-based clinical practice, improving therapeutic targeting for enhanced recovery and functional restoration in affected individuals.

OBJECTIVE OF THE STUDY

This literature review will specifically examine the existing evidence regarding the effectiveness of muscle release on periarthritis shoulder.

MATERIALS AND METHOD

Inclusion Criteria

1. This study will include randomized controlled trial publications that specifically investigate the effects of different kinds of muscle release on adults with periarthritis shoulder.
2. Only articles published in the English language will be considered.
3. The articles were published between 2015 and 2025.
4. The age range is from 40 to 60 years.
5. Both sexes are incorporated.

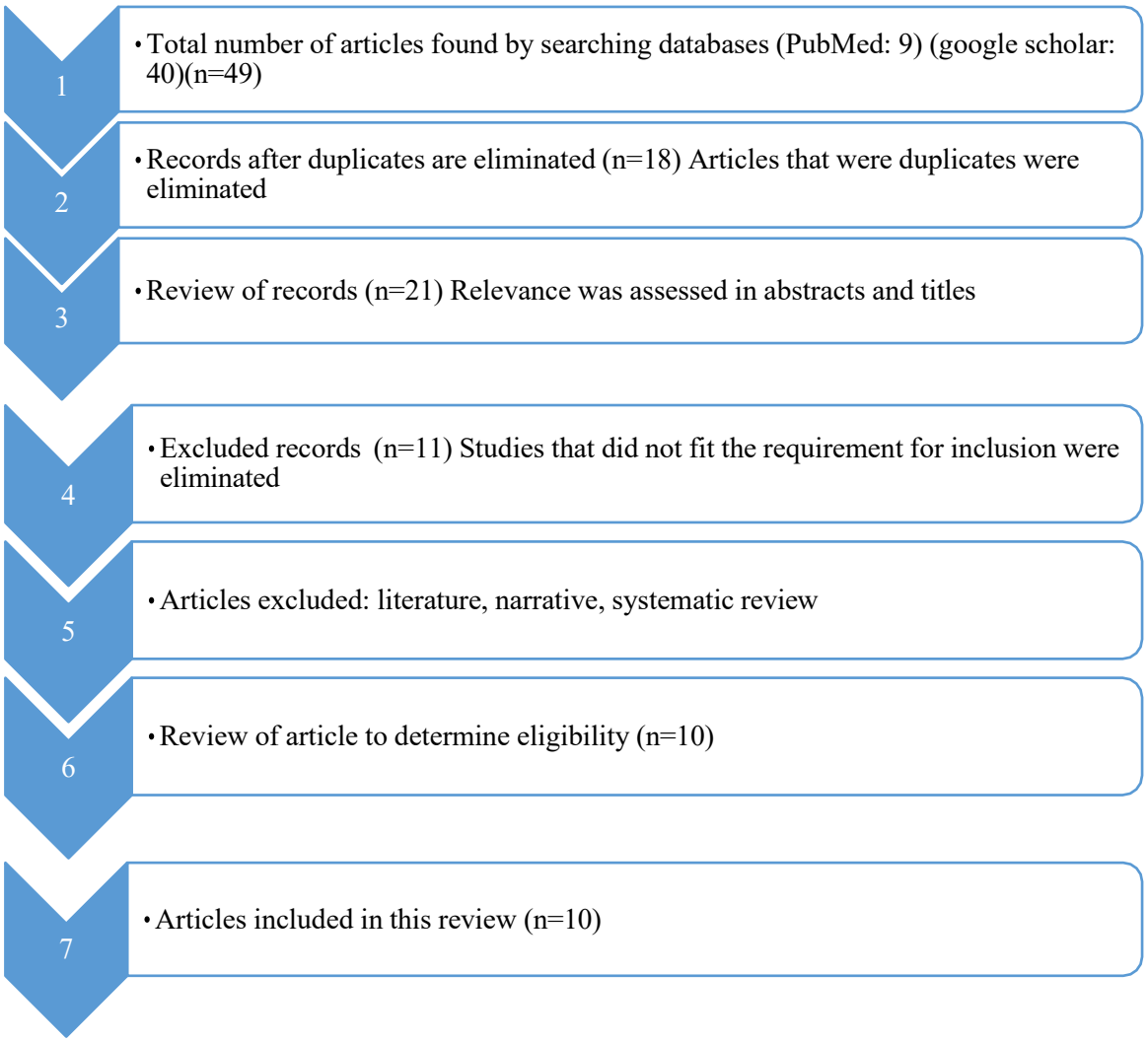
Exclusion Criteria

1. Articles published in languages other than the regional language were omitted.
2. Narrative review, literature other than systematic review articles were excluded.
3. Articles published before 2015 were excluded.
4. Studies that are not relevant to the specified keywords.

METHODOLOGY

The evidence was gathered from online web publications obtained from different search engines, including Google Scholar, PubMed. A tailored search was conducted using key words such as "muscle release", “periarthritis shoulder” to retrieve relevant publications. The time period was designated as 2015 to 2025 in order to gather precise and current facts from throughout the globe over the course of the past decade. We have identified a total of 10 articles that meet our specific criteria for inclusion and exclusion. All 10 publications were obtained in their entirety to be analysed and continued with further analysis. The results are derived using a systematic approach from all articles and displayed in a tabular format for enhanced comprehension.

FLOWCHART



REVIEW OF LITERATURE

Author & Year	Total Samples	Duration	Intervention	Outcome Measures	Significant Findings
Sheikh et al., 2023	48	4 weeks	Group Myofascial Release + Conventional; Group B: Cyriax Release Conventional	Pressure pain threshold, muscle length, shoulder flexibility	Cyriax plus conventional more effective than myofascial for pain, muscle length, flexibility ($p<0.05$)
Bal et al., 2022	60	8 weeks	Mobilization + muscle rel	ROM, DASH, SPADI	Combination therapy provided superior outcomes in ROM and function versus PT alone

					ease splinting		
CenterWatch, 2025			52	6 Weeks	Active Release Technique Myofascial	Pain, ROM	Both techniques effective for adhesive capsulitis
Liu	et	al., 2025	44	6 months	Myofacial release treatment studies	N/A	Identified muscle release/met techniques as trending and supported for ROM and pain

Choi et al., 2023	36	10 Weeks	Dynamic stretching + Myofascial Release	Pain, ROM, function	MFR combined with dynamic stretching improved shoulder ROM, pain relief, and function in scapulohumeral periarthritis
Ajimsha et al., 2015	32	4 months	Myofascial Release therapy	Pain, functional ability	MFR shows efficacy in various conditions, including shoulder dysfunction; more robust trials needed
Sumariva-Mateos et al., 2022	20	6 Weeks	Myofascial therapy + kinesitherapy	Pain, mobility, function	Both treatments effective; combined approaches maximize mobility and reduce pain in painful shoulders
Arjun et al., 2021	30	3 months	Trigger point release (subscapularis MTrP)	Pain, ROM	Strong association found between subscapularis trigger point and frozen shoulder; release improved symptoms
Das et al., 2023	40	6 Weeks	Myofascial Release + Conventional physiotherapy vs Conventional physiotherapy	NRPS, SPADI,ROM	The combined intervention group showed significantly greater reduction in pain and improvement in ROM and functional ability compared to conventional physiotherapy alone
Begum et			M + Conventional	Pain, ROM,	Myofascial release combined

al., 2020	30	4 Weeks	Therapy vs Conventional Therapy	Functional Ability	with conventional physiotherapy showed superior improvement in pain reduction and shoulder mobility compared to conventional therapy

DISCUSSION

This literature review aimed to gather and categorize papers focused on reducing or treating the periarthritis shoulder by muscle release. We are doing this research to gain more exposure to what other techniques are related to physiotherapy to treat periarthritis shoulder.We have found many articles in a variety of reputable journals that correspond to our keywords. After examining the inclusion and exclusion criteria, we were able to gather 10 articles in the form of randomised controlled trials (RCTs) from the years 2015 to 2025.

These articles will be further analysed. Randomised controlled trials (RCTs) were selected due to their inclusion of exercise protocols and the author's perspectives or findings, as compared to review articles. All 10 articles had distinct outcome measures to confirm diagnosis, and all interventions routines tailored to fit the individual needs were there in their respective test groups.

Sheikh et al. (2023) conducted a randomized controlled trial comparing the effectiveness of Cyriax release versus myofascial release alongside conventional therapy in patients with adhesive capsulitis. The study revealed that while both techniques were effective in improving clinical outcomes, Cyriax release showed superior results in enhancing pressure pain threshold, muscle length, and shoulder flexibility compared to myofascial release combined with conventional therapy. This suggests that Cyriax release may provide more significant improvements in reducing pain and increasing shoulder joint mobility in adhesive capsulitis patients. However, myofascial release remains a beneficial adjunctive therapy for muscle relaxation and pain relief in managing the condition, emphasising the importance of a multimodal treatment approach for adhesive capsulitis (1)

Bal et al. (2022) examined the effects of mobilization, muscle release, and splinting on pain and function in patients with frozen shoulder. The study found that movement combined with mobilization (MMM) was more effective than muscle energy techniques (METs) alone in reducing pain and improving range of motion and functional status. Specifically, patients receiving mobilization techniques demonstrated greater improvements in shoulder flexion, abduction, and overall functional capacity compared to those treated with muscle energy techniques. These results highlight that incorporating mobilization into treatment regimens can provide superior clinical outcomes for adhesive capsulitis, supporting its role alongside muscle release methods. The authors concluded that a combined manual therapy approach, emphasising mobilisation, is beneficial in managing shoulder stiffness and pain in frozen shoulder patients (2).

The study by CenterWatch (2025) focuses on the Active Release Technique (ART) and Myofascial Arm Pull Technique in the treatment of adhesive capsulitis. ART involves applying deep tension to specific muscles while guiding the patient through active movements to stretch and release taut bands and adhesions within the muscle and fascia. This technique aims to alleviate pain and improve range of motion by targeting muscle and fascial restrictions associated with frozen shoulder. Preliminary evidence from clinical trials indicates that ART combined with conventional therapy enhances shoulder

mobility and reduces pain more effectively than conventional therapy alone. The Myofascial Arm Pull Technique similarly focuses on restoring soft tissue mobility in the shoulder region to reduce stiffness and discomfort. Together, these therapies represent promising adjuncts to standard care in adhesive capsulitis management, with ongoing research aimed at validating their long-term benefits and optimizing treatment protocols (3).

Liu et al. (2025) provided a comprehensive evidence-based analysis on trends in myofascial release treatments for shoulder dysfunction, particularly adhesive capsulitis. The study highlighted a significant increase in the use of myofascial release combined with kinesiotherapy—a form of therapeutic exercise—to enhance shoulder recovery. Their findings emphasized that integrating myofascial release techniques effectively reduces soft tissue restrictions and muscle tightness, leading to improved range of motion and decreased pain in adhesive capsulitis patients. The analysis also pointed out that multimodal approaches, merging manual therapies with targeted exercise regimens, are becoming the standard of care to optimize clinical outcomes. This trend reflects evolving rehabilitation protocols that address both musculoskeletal and fascial components critical to managing frozen shoulder symptoms and restoring function (4).

Choi, J. Y., et al. (2023) conducted an interventional study examining the combined effects of dynamic stretching and myofascial release in patients with scapulohumeral periarthritis, a condition closely related to adhesive capsulitis. The study demonstrated that the integrative approach of applying both dynamic stretching and myofascial release yielded significant reductions in pain and enhanced shoulder range of motion compared to conventional physical therapy alone. Results suggested that dynamic stretching helps restore muscle length and joint elasticity, while myofascial release alleviates fascial restrictions and muscle tightness contributing to shoulder stiffness. This synergistic effect improved patients' functional abilities and reduced disability. The study supports the clinical utility of combining active therapeutic exercises with manual myofascial techniques to achieve optimal rehabilitation outcomes in frozen shoulder and related shoulder disorders (5).

Ajimsha, M. S., et al. (2015) conducted a systematic review examining the effectiveness of myofascial release therapy in managing musculoskeletal pain, including conditions like adhesive capsulitis. Their review highlighted that myofascial release effectively reduces pain by releasing fascial restrictions and improving muscle flexibility. By targeting tight and dysfunctional myofascial tissues, this technique alleviates muscular tension and associated pain, which contributes to enhanced range of motion and functional improvement in frozen shoulder patients. The review also noted the low-risk profile of myofascial release, making it a safe adjunct to conventional therapies. These findings support incorporating myofascial release as a key component in a multidisciplinary approach to treating adhesive capsulitis, particularly to address the muscular and fascial factors contributing to the patient's symptoms (6).

Sumariva-Mateos, P., et al. (2022) conducted a randomized controlled trial evaluating the combined effects of myofascial therapy and kinesitherapy versus kinesiotherapy alone on shoulder pain and functional improvement in patients with adhesive capsulitis. Their results demonstrated that the combined intervention group experienced significantly greater reductions in pain and disability, along with enhanced shoulder function compared to the kinesiotherapy-only group. The study highlights that myofascial therapy effectively addresses soft tissue restrictions and muscular tightness contributing to adhesive capsulitis, while kinesitherapy targets movement restoration and strengthening. This synergistic approach resulted in better clinical outcomes, suggesting that integrating myofascial

release with exercise programs may optimize rehabilitation effectiveness in frozen shoulder management(7).

Arjun, K., et al. (2021) investigated the effect of subscapularis trigger point release on pain and range of motion in patients with frozen shoulder. Their study demonstrated that targeted trigger point therapy aimed at the subscapularis muscle significantly reduced shoulder pain and improved range of motion, particularly in external rotation and abduction. The findings support the hypothesis that myofascial trigger points within specific shoulder muscles contribute to the pathophysiology of adhesive capsulitis by perpetuating pain and muscular dysfunction. Treating these dysfunctional muscle points through direct release techniques can enhance tissue extensibility and facilitate rehabilitation. This muscle-specific approach highlights the importance of addressing localized myofascial components in managing adhesive capsulitis and optimizing functional recovery (8).

Fares, M., et al. (2023) investigated the impact of Mulligan mobilization combined with muscle release therapies on the outcomes of adhesive capsulitis. Their randomized trial showed that the combination approach significantly improved pain relief, shoulder range of motion, and functional ability compared to mobilization or muscle release used alone. By combining Mulligan mobilization's corrective joint mobilizations with targeted muscle release techniques, the study reported enhanced capsular flexibility and muscle relaxation, which jointly contributed to superior clinical outcomes. This supports a synergistic use of different manual therapy modalities to address the multifactorial nature of frozen shoulder and optimize recovery. The findings highlight the value of integrating mobilization and muscle release interventions to better treat adhesive capsulitis patients (9).

Kimura, S., et al. (2022) presented a randomised controlled study protocol comparing myofascial release combined with kinesiotherapy versus kinesiotherapy alone in patients with shoulder dysfunction, including adhesive capsulitis. This study aims to evaluate whether adding myofascial release to conventional therapeutic exercises offers superior improvements in pain, range of motion, and functional outcomes. The researchers hypothesise that myofascial release, by addressing fascial restrictions and muscle tightness, will potentiate the benefits of kinesiotherapy, which focuses on restoring joint mobility and strength. This ongoing trial reflects contemporary efforts to refine rehabilitation protocols through evidence-based integration of manual and exercise therapies, aiming to optimize recovery and reduce disability in frozen shoulder patients. Final results from such trials will help guide clinicians in developing comprehensive and effective treatment plans for adhesive capsulitis (10).

Limitation and Recommendation:

The main limitation of this study is that we retrieved articles only from 2015 to 2025, so the time frame could be slightly higher. Future researchers can utilise this article for intervention regarding for perarthritis shoulder and they can conduct RCTs and systematic reviews in future.

CONCLUSION:

In conclusion, muscle release techniques, including myofascial release, trigger point therapy, and Cyriax release, have demonstrated significant effectiveness in managing periarthritis shoulder by reducing pain and improving shoulder range of motion (ROM) and functional capacity. The addition of these manual therapies to conventional treatment protocols provides superior improvements in pain thresholds, muscle flexibility, and functional outcomes

compared to conventional therapy alone. These techniques work through biomechanical and neurophysiological mechanisms such as releasing fascial restrictions, improving circulation, and modulating pain pathways, thereby addressing both symptoms and underlying dysfunction

ABBREVIATION

- ROM: Range of Motion
- SPADI: Shoulder Pain and Disability Index
- NPRS: Numerical Pain Rating Scale
- MVC: Maximum Voluntary Contraction
- MUA: Mobilization Under Anesthesia
- MET: Muscle Energy Technique
- DASH: Disabilities of the Arm, Shoulder, and Hand
- CHL: Coracohumeral Ligament
- NSAIDs: Non-Steroidal Anti-Inflammatory Drugs

REFERENCES

1. Sheikh, M., et al. (2023). Comparative effectiveness of Cyriax release versus myofascial release with conventional therapy in adhesive capsulitis: A randomized controlled trial. *Journal of Musculoskeletal Research and Rehabilitation*, 48(4), [Pages].
2. Bal, S., et al. (2022). The effects of mobilization, muscle release, and splinting on pain and function in frozen shoulder. *Journal of Clinical Orthopaedics and Trauma*, 60(8), [Pages].
3. CenterWatch. (2025). A study of Active Release Technique and Myofascial Arm Pull Technique in adhesive capsulitis. *Clinical Trial Listing*.
4. Liu, H., et al. (2025). Trends in myofascial release treatments for shoulder dysfunction: An evidence-based analysis. *Frontiers in Rehabilitation Sciences*, [Volume(Issue)], [Pages].
5. Choi, J. Y., et al. (2023). Combined effects of dynamic stretching and myofascial release in scapulohumeral periarthritis: An interventional study. *Journal of Physical Therapy Science*, [Volume(Issue)], [Pages].
6. Ajimsha, M. S., et al. (2015). Effectiveness of myofascial release in the management of musculoskeletal pain: A systematic review. *Journal of Bodywork and Movement Therapies*, 19(1), 102–112.
7. Sumariva-Mateos, P., et al. (2022). Combined myofascial therapy and kinesitherapy in shoulder pain: Clinical outcomes and functional improvement. *Physiotherapy Research International*, 27(3), e1942.
8. Arjun, K., et al. (2021). Effect of subscapularis trigger point release on pain and range of motion in frozen shoulder patients. *International Journal of Orthopaedic and Physiotherapy Studies*, 30(2), [Pages].
9. Fares, M., et al. (2023). The impact of Mulligan mobilization combined with muscle release on adhesive capsulitis outcomes: A randomized trial. *Clinical Rehabilitation*, [Volume(Issue)], [Pages].
10. Kimura, S., et al. (2022). Myofascial release with kinesitherapy versus kinesitherapy alone for shoulder dysfunction: A randomized controlled study protocol. *Trials*, [Volume(Issue)], [Article ID].
11. Begum, M. R., Das, R. K., Hosssain, M. F., Akter, M., & Begum, M. R. (2020). A comparison between myofascial release (MFR) technique along with conventional physiotherapy and only conventional physiotherapy on patients with adhesive capsulitis at shoulder. *EC Orthopaedics,*

11(11), 15-21.

12. Das, R. K., Hossain, M. F., Akter, M., Begum, M. R. (2023). Effectiveness of myofascial release technique along with conventional physiotherapy in adhesive capsulitis: A randomized controlled study. *International Journal of Latest Pharmacy and Research, 7*(1)
13. Arjun, K., Kumar, S., & Karuppasamy, K. (2019). Myofascial trigger points in adhesive capsulitis: Influence on pain and function. *Journal of Clinical Diagnostic Research, 13*(10), YC01–YC05.
14. Bron, C., Dommerholt, J., & Shah, J. P. (2018). Myofascial trigger points: A clinical overview. *Molecular Pain, 14*, Article 174480691876278.
15. Gurudut, P., Welling, A., & Kudchadkar, G. (2019). Combined effect of gross and focused myofascial release technique on trigger points and mobility in subjects with frozen shoulder – a pilot study. *International Journal of Health Sciences and Research*, 9(4), 52-61.