Upper Extremity

A 2013 systematic review concluded:

Fair evidence (Grade B) for manual and manipulative therapy (MMT) alone or in combination with multimodal treatments for
   Lateral epicondylopathy in short term (≤ 3-6 months)\textsuperscript{1}
   Carpal tunnel syndrome in short term\textsuperscript{1}
   TMJ disorders in short term\textsuperscript{1}
Insufficient evidence (Grade I) for MMT and multimodal treatment for other wrist, hand and finger disorders in the short term\textsuperscript{1}
Multimodal treatments include manipulation, mobilization, exercise, strengthening and stretching, soft tissue therapies, mobilization or manipulation instruments, proprioceptive neuromuscular facilitation, splinting or orthoses, electrical and mechanical modalities and other myofascial, functional and soft tissue techniques\textsuperscript{1}

A 2014 systematic review and meta-analysis found that spinal manipulation “appears to be no better or inferior than any other interventions” in the management of upper limb pain. It was cautioned that evidence was very low and more research is necessary, especially high quality RCTs.\textsuperscript{2}

Shoulder

A 2011 systematic review concluded:

Fair evidence (Grade B) for MMT alone or in combination with multimodal treatments for
   Rotator cuff injuries disease or disorder\textsuperscript{3}
   Shoulder complaints, disorders, dysfunction and/or pain\textsuperscript{3}
   Adhesive capsulitis (especially helpful was the inclusion of proprioceptive retraining)\textsuperscript{3}
   Soft tissue disorders (focus on soft tissue or myofascial treatments)\textsuperscript{3}
Limited evidence (Grade C) for cervical lateral glide mobilization and/or HVLA (including soft tissue release and exercise) for
   Minor neurogenic shoulder pain (aka minor peripheral nerve injuries and/or disorders)\textsuperscript{3}
Insufficient level of evidence (Grade I) for MMT alone or in combination with multimodal treatments for
   OA\textsuperscript{3}

References

