Dear Editor:

Thank you for the opportunity to respond to Mr Ploski's and Dr Schrader's concerns regarding our study that compared compressive myofascial release and the Graston Technique (GT) for improving ankle-dorsiflexion range of motion. The authors of this letter were concerned with the description of the methods used in our study.

We would like to clarify that it would have been more appropriate for us to have referred to our treatment protocol either as a *modified GT treatment* or as *instrument-assisted soft tissue mobilization using the Graston instruments*. We acknowledge that we did not implement the full protocol as outlined in the *Graston Technique Module 1 Training Manual*,¹ specifically the posttreatment stretching and the strengthening and neuromuscular reeducation. However, we did state this omission in the "Limitations" section as a potential reason for the observed results.

Although we did not address stretching or strengthening and neuromuscular reeducation, we do believe we followed the instrument-application protocol according to the GT manual. This is not to imply that following the instrument portion alone constitutes performance of the full GT protocol. Instead, it was our effort to acknowledge the unique aspects of the education and training that compose the GT while still attempting to control for confounding variables.

Conforming to GT principles, we did use a warm-up as noted in our article,² which stated, "Regardless of group allocation, all participants completed a 5-minute bicycle warm-up before beginning their assigned intervention."^(p162) We attempted to follow the recommendations from the training manual for the entire instrumentapplication portion of the treatment protocol for those individuals assigned to the GT group. Specifically, these recommendations advise treating a region or muscle group for 3 to 5 minutes, with larger regions potentially taking longer. Our protocol followed these recommendations for assessing and scanning the tissue using the sweep stroke with the GT5 instrument for 1 minute and treating areas of restriction for 4 minutes using the sweep, fan, and strum strokes in various directions. All of these unique assessment and treatment strokes are part of the GT education and training. Based on the targeting of the triceps surae muscle group and our clinical experience, we felt that 5 minutes was within the recommendations for this size region or muscle group.

As with any research study, our methods had limitations, and we believe we acknowledged these accordingly. In particular, we noted that the full GT protocol was not followed. We are not disputing that it was inappropriate to call the protocol used in the current study the GT. However, the purpose of this study was to compare 2 manual therapy techniques aimed at improving ankle dorsiflexion while limiting potential confounding variables. We believe our findings provide valid and useful clinical information on the effectiveness of instrument-assisted soft tissue mobilization for improving ankle-dorsiflexion range of motion in a sample of participants with a dorsiflexion deficit.

> Justin Stanek, EdD, ATC Illinois State University, Normal

REFERENCES

- Loghmani MT, Schrader JW, Hammer WI. Graston Technique Module 1 Training Manual. Indianapolis, IN: Graston Technique, LLC; 2017.
- 2. Stanek J, Sullivan T, Davis S. Comparison of compressive myofascial release and the Graston Technique for improving ankle-dorsiflexion range of motion. *J Athl Train.* 2018;53(2):160–167.