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EXPRESSION

CRANIAL OSTEOPATHY: ITS FATE SEEMS CLEAR

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Background: According to the original model of cranial osteopathy, intrinsic rhythmic movements of the human brain cause rhythmic fluctuations of cerebrospinal fluid and specific relational changes among dural membranes, cranial bones, and the sacrum. Practitioners believe they can palpably modify parameters of this mechanism to a patient's health advantage.

Discussion: This treatment regime lacks a biologically plausible mechanism, shows no diagnostic reliability, and offers little hope that any direct clinical effect will ever be shown. In spite of almost uniformly negative research findings, "cranial" methods remain popular with many practitioners and patients.

Summary: Until outcome studies show that these techniques produce a direct and positive clinical effect, they should be dropped from all academic curricula, insurance companies should stop paying for them; and patients should invest their time, money, and health elsewhere.

Background

"Truth is great, certainly, but considering her greatness, it is curious what a long time she is apt to take about prevailing." --TH Huxley, 1894 [1(p218)]

With all I've learned in recent years about human credulity, it remains difficult for me to fathom how little influence fact sometimes has over behavior. For example, 21st century science-based medicine is forced to cope with numerous unfalsifiable (or already falsified) claims from practitioners of the euphemistically labeled "complementary" or "alternative" medical arts, many with names familiar to all: homeopathy, therapeutic touch, reflexology, aromatherapy, magnet therapy . . . and on, and on, and on. A form of health care of particular interest to readers of this journal which can fairly be labeled "alternative," is cranial osteopathy [2,3,4] / craniosacral therapy [5]. According to the original biological model [2,3,4], intrinsic rhythmic movements of the brain (independent of respiratory and cardiovascular rhythms) cause rhythmic fluctuations of cerebrospinal fluid and specific relational changes among dural membranes, cranial bones, and the sacrum. Practitioners believe they can palpably monitor and modify parameters of this mechanism (or a similar mechanism, for example reference [5]) to a patient's health advantage.

Discussion

Here, focusing on cranial osteopathy, is a cautionary tale inspired by the recent collision of a prescientific, medical reverie with reality in southern Maine.

Once upon a time . . .

. . . with the best of intentions, William Garner Sutherland invented cranial osteopathy [2].

Over the years, practitioners convinced themselves that oh-so-gentle palpation of the cranium, guided through understanding of Sutherland's "Primary Respiratory Mechanism," could improve an astounding range of maladies manifesting throughout the human body [6].

Over the years, in both formal (e.g., classroom) and informal (e.g., clinical) settings, ever more students and practitioners learned of Sutherland's (or Upledger's related) [5(p11)] mechanism and abundant anecdotal success with patients.

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PRESIDENT'S REPORT — DR BRETT HOULDEN

Dr Brett Houlden

Hello, its spring already and what a great time to look forward to all the happenings in your life, your practice and indeed, your SOT organisation.

The year ahead promises to continue the great momentum of your organisation. What a wonderful series presented in 3 cities up the east coast, and over in New Zealand too, and for the first time, PERTH! You and your board were looking forward to getting to present SOT over there, and this year it went off with a bang, and already the plans are well underway to be there again next year.

In late October we have the amazing Dr Marc Pick to present at our Annual Convention, which will be a not-to-be-missed event. For those of you who have not seen Dr Pick yet, he is a treasure trove of amazing anatomy and physiological and neurological knowledge. He is specifically chatting about the neurology of the categories and how to work with them.

I love SOT, and I hope you will assist me in continuing to strive to be not only the best practitioner you can be, but also forward thinking in developing your SOT skills. Please give your support towards your board, in teaching or support roles is valuable, and indeed necessary for your organisation to thrive. You can give as much or as little as you are able. Your encouragement of fellow chiropractors who you know use SOT or are interested in becoming SOT members would also help lift our organisation to even greater heights.

Your organisation will go as far as you help it to go, how far will you propel it?

Yours Enthusiastically,
Brett Houlden

CRANIAL OSTEOPHATHY: IT'S FATE SEEMS CLEAR - CONT'D

Patients were healed, careers were established, and all was good . . . . . then reality weighed in:

1) As an underlying rationale, the Primary Respiratory Mechanism (including Upledger's "craniosacral" adaptation) [5] has failed utterly:

A. Evidence and biological common sense entirely invalidate Sutherland's mechanism [7,8].

B. Diagnoses based on this mechanism feature not just low reliability but no reliability. There is no evidence, whatsoever, that different practitioners perceive similar phenomena or even that perceived phenomena are real [7,8].

2) After most of a century, no successful, properly controlled outcome analyses have been published. Practitioners have no scientific evidence that their therapeutic actions–however grounded in biology (or metaphysics)–have any direct effect on patient health.

Since 2002, Dr. James Norton and I, together or separately, publicly or privately, and on many occasions have shared our "cranial" skepticism with colleagues around the world, including those at the American Osteopathic Association, the National Board of Osteopathic Medical Examiners (U.S.A.), and the Journal of the American Osteopathic Association. In addition, we have offered our science-based, heavily referenced, critical impressions to readers of *The Scientific Review of Alternative Medicine* (United States) [7,8], *Physical Therapy* (United States) [9], *Ostium* (Australia) [10,11], *The Osteopath* (United Kingdom) [12], *The International Journal of Osteopathic Medicine* (United Kingdom) [13], and in the form of several French translations [14,15]. With many of our publications, letters, Emessages, and personal communications, we have invited practitioners to inform us of scientific work we may have missed or misinterpreted. Knowledge of such might prompt us to reconsider our negative conclusions regarding the biological mechanism, diagnostic reliability, and clinical efficacy of cranial osteopathy/craniosacral therapy. After four years since our first joint publication, we remain unaware of published, substantive rebuttals or of work suggesting that our views should be refined in any way.

The End?

Well, it should be but it's not. The therapeutic ministrations of many "cranial" practitioners derive directly from the now invalidated, anomalous Primary Respiratory Mechanism. This means that up-to-date practitioners no longer have even the imaginary biology of Sutherland's mechanism to explain what they do or why they believe it works. Some clinicians of my own college of osteopathic medicine disavow intellectual allegiance to the mechanism but cling to it as a "teaching metaphor" . . . because they otherwise lack even this failed biological device to unify and explain their diagnostic and therapeutic propositions. Some counter criticisms by changing the subject to the perceived array of poorly understood conventional treatments. Many deflect criticism by focusing, instead, on their perceived (but scientifically almost meaningless) personal clinical success. Many practitioners around the world disown Sutherland's biology-based mechanism altogether (or were trained in a somewhat different model) and instead engage objectively immeasurable body energies [16(p169-

HIATUS HERNIA & S.O.T.

The Hiatus hernia problem which we see as part of a Category II is one of the most common problems found in patients of all ages. The test and correction description which takes up a mere three lines in our current SOTO Australasia Seminar notes (1) perhaps does not do justice to this most useful and helpful procedure.

On the topic of hiatal hernia, De Jarnette states “Next to the TMJ, the Hiatal hernia is the most prevalent overlooked problem, in Chiropractic” (2). In SOT Seminars of the early 80’s, the term PHH or pseudo-hiatal hernia came into usage. The reason was that the only medically (and insurance company) acceptable diagnosis of the "diaphragmatic hernia" or 'hiatus hernia' was the barium X Ray. Perhaps a better description may have been 'subclinical hiatus hernia' or 'subacute hiatus hernia syndrome'. As a subacute condition and one the patient most often fails to mention, 'reflux'(pseudo- hiatal hernia), subclinical hiatus hernia, subacute hiatus hernia syndrome, diaphragmatic hernia, and hiatus hernia) and the techniques to handle it are an important part of your SOT protocol.

Clinical Indicators

Dr Ralph Failor (3) has suggested four indicators. These are:

1. Position-wise, the hiatus is at about the vertebral level of T10. Failor‘s suggestion is that palpatory tenderness will be found more on the left of T10 vertebra.

2. Palpatory tenderness is noted in the supine patient just to the left of the xiphoid process pressing gently upwards and towards the patients left shoulder.

3. Tenderness at the 3rd intercostal space. (SOT Cat II protocol)

4. Palpatory tenderness at the intercostal space directly down from the axilla on the left lateral side of the thoracic cage.

De Jarnette reminds us that the HH can be 'part of the Category II or no category today (4) and has stated, "When this is a health problem, mind language is perhaps the best way to detect its presence. (5)

In recognizing HH as being part of the fifth thoracic dural port closure, Dr Rees also suggested that these patients have had and may still have a liver problem (6). (Liver technique is fully described in your CMRT notes).

On this subject, Dr Rees did a pretty good job of describing the HH. In. his words, "The vitality to the gastro-oesophageal vestibule, also called the gastric antrum or antechamber of the stomach, which is that portion situated just before the cardiac orifice of the stomach, is in dire straits and needs your immediate help to clear the 'reflux esophagitis' (pseudo hiatal hernia) symptoms that are scaring the daylights of your patient who just knows he is having a heart attack" (7).

Symptoms

Symptoms may or may not be present, which is the nature of the viscera and its nerve supply. The indicator systems of SOT and CMRT serve as a wonderful system to determine the status of the viscera.

Having stated this, Failor (8) gave a long list of the possible hiatal hernia syndrome symptoms, included here:

Fatigue The patient will get up in the morning more tired than when he retired.

Lack of mental acuity The patient will complain of just not being able to think clearly. Students will have difficulty in obtaining passing grades.

Appetite limited The patient is often able to eat only small meals and in a matter of two hours will be hungry.

Keep breath curtailed The patient is unable to take a deep breath, usually only about one third of the average,

Exhaustion The patient will become exhausted on the slightest exertion.

Spare tyre The patient will have a 'spare tyre' bulge across the upper abdomen, just below the rib cage.

Pseudo Goitre The patient may experience a full feeling at the base of the throat as if there were a goitre.

Heavy Chest The patient will have a constant heavy feeling in the chest as if something was pressing on it.

Regurgitation The patient will experience a regurgitation of the eaten food many times. Or, it may go part way down to the stomach and stop, giving discomfort and pain.

Darting Pains a large majority of patients will experience slight to heavy darting pains across the upper thoracic cage at intervals, especially after a large meal.

Tickling Cough The patient will have a tickly cough at the base of the throat. However, the cough will produce nothing.

Sensitive Waist The patient will not be able to stand anything tight around the waist, the sensitivity being more pronounced after eating.

FROM THE EDITOR'S PEN

Welcome to another action packed edition, I hope you have all been as busy and productive in practice as I have. This year has flown by and we are not only in the count down to Christmas but also the annual general meeting and convention seminar which is being headlined by none other than mark Pick.

I strongly suggest that you go along and call any chiropractors that you know who may be struggling to understand how the body and especially the nervous system works and bring them along. Mark is a presenter **not to be missed**, it is a credit to our board's hard work that they have arranged such a well published, credentialed and thoroughly interesting person for you to learn from. Get yourself to Melbourne.

In this Edition I have an interesting article from SE Hartman about cranial work, it should hopefully stir up some thought and maybe some comments. If anyone has any views they would like to express regarding this piece or any others, please email them to me and I will start an opinions/views column in the next issue.

Further to this I will also run a rebuttal comment in the next issue from the remarkable Charles Blum et al which should also prove stimulating reading but was too large to place in the current format.

I hope to be receiving feedback soon. See U at the AGM

Scott

ATHLETE SEEKS SOT HELP

The following case study is an example of how effective SOT chiropractic care really is.

The practitioner is Graeme Piera, advanced chiropractic practitioner of SOT for 35 years. The patient treated is Gary Jackson, 34 year old Australian cycling champion. This excerpt is taken from ……

Garry, a 34 year old racing cyclist from Bairnsdale, Victoria presented to me with a problem. He described himself as being fit and healthy with almost no pain at all, but something was wrong; he was not racing at his usual level. He felt uncomfortable on his bike seat, almost as though he was sitting 2cm over to the left and he could also feel his left leg going numb when peddling (sic) hard in races. This was unusual as he had never had this type of problem before.

Physical examination of both legs indicated that Garry was in peak condition with highly developed upper and lower leg muscles. Only after muscle strength testing was it noticed that the gluteals and the quadriceps were marginally weaker on the left side.

Palpation of the lumbar spine and pelvis could not elicit any real tenderness. A positive arm fossae test and a positive double leg raise with cervical compaction indicated that there was an active Category II on the left side.

Treatment consisted of Category II blocking (patient supine, high block under the left PSIS, low block under the right ischium) with subsequent arm-fossae re-checking at 30 second intervals. After repeated tests, the arm-fossae response was very much improved. This improvement was obvious to Garry also.

A follow up visit was scheduled for 3 days time and Garry was put through the same work-up as before. Garry could see for himself that no Category II signs were present and he felt sure the next time he got on the bike things would be different. His next visit was scheduled for a week later and in the meantime he was advised to go for a ride and see what would happen.

A week later he reported that he felt much more comfortable on the bike and that his leg was not going numb under the stress of pushing in a racing situation. Some minor lumbar spine adjustments were performed but he was not a Category II on this day.

A few weeks later he won the Australian 500 meter time trial at the Australian Masters Track Championships.

Recently Garry had a check-up and stated

'After the treatment, I immediately noticed that I was sitting straighter and felt more comfortable on the bike. Now that a few weeks have passed, I feel as though the left leg has become stronger and therefore more balanced in power compared to the right leg. Even the numbness after prolonged peddling (sic) disappeared. I feel normal again.'

Gary Jackson on his bike Bairnsdale Advertiser '*Jackson returns to track with success*' March 21, 2005

Just goes to show, your patient doesn't need to be in pain to be subluxated. Do the tests, adjust accordingly and then retest. The pre and post-tests used in SOT are an invaluable tool. They let the doctor and the patient know when the correction has occurred. Don't guess… perform the test!

Graeme Piera, D.C

THE EVOLUTION OF BLOODLESS SURGERY AND CHIROPRACTIC

Bloodless surgery or chiropractic manipulative reflex technique (CMRT) encompasses the relationship between somatovisceral and viscerosomatic reflexes and therefore between the somatic and autonomic nervous systems. In his book *Anatomy: Regional and Applied* R. J. Last points out:

"There is only one nervous system. It supplies the body wall and limbs (somatic) and viscera (autonomic). Its plan is simple. It consists of afferent (sensory) and efferent (motor) pathways, with association and commissural pathways to connect and coordinate the two. There is no more than this, in spite of the many pages devoted to its study." [1]

Bloodless Surgery has historically been used in chiropractic as a term describing soft tissue treatment affecting an organ and its related vertebral relationship or viscerosomatic and somatovisceral reflexes [2, 3]. Bloodless surgery has also been used to describe methods of manipulating joints and soft tissue not related to the viscera. [4]

James F. McGinnis was a chiropractor that relocated to California in the early 1920s, where he earned a naturopathic doctorate. In the 1930s he became one of the best known of several chiropractic bloodless surgeons and traveled around the nation to teach his methods [2]. Around this time Major Bertrand DeJarnette, developer of Sacro Occipital Technique, was also practicing and teaching extensive methods of bloodless surgery. DeJarnette published a comprehensive book on the topic entitled, *Technic and Practice of Bloodless Surgery* in 1939, which remains the most complete discussion on the topic to date. [3]

Bloodless Surgery has been used and taught by SOT Chiropractors since 1939.

During this time DeJarnette used chromotherapy, which was purported to affect the physiology of the patient. The process involved the "filtering of white light through special screens or filters" [5] through a mechanism called the chromoclast. He would use this devise to help with his bloodless surgery procedures and found that it appeared to have among other therapeutic characteristics, anesthetic properties. During the 1940s DeJarnette stopped teaching and selling the chromoclast and one theory was that the many dentists that had used his devise for anesthetic all switched to topical and injectable anesthetics such as Novocain at that time.

He continued to teach and practice bloodless surgery through the 1940s and began its modification to use more reflex applications and referred pain indicators as a method of affecting organ symtomatology. In the 1950s he furthered his investigations into reflexes and their affect on the viscera and related vertebra. By the early 1960s DeJarnette had modified the nature of Sacro Occipital Technique's method of bloodless surgery from its 1939 procedures, which might take 2-4 hours of preparation and treatment, to procedures that could be practiced in a span of 15 minutes [6,7]. For a multiple reasons he decided to change the name of his method of affecting referred pain pathways, viscerosomatic/ somatovisceral reflexes, and direct organ manipulation to be called Chiropractic Manipulative Reflex Technique (CMRT).

CMRT is used as a method of treating the spine or vertebra visceral syndromes associated with viscerosomatic or somatovisceral reflexes [8-10], dysafferentation at the spinal joint complex [11] and visceral mimicry type somatic relationships [12]. Treatment involves location and analysis of an affected vertebra in a reflex arc by way of occipital fiber muscular palpation, similar to trigger point analysis or Dvorak and Dvorak's spondylogenic reflex syndromes [13]. Once specific vertebra reflex arcs are located, corroborated with referred pain pathways, and clinical symtomatology, then the specific vertebra to be treated is isolated by pain provocation, muscle tension, and vasomotor symtomatology. Often times if a vertebral dysfunction is chronic or unresponsive to chiropractic spinal manipulation then a viscerosomatic or somatovisceral component is evaluated [14]. Treatment of the viscerosomatic or somatovisceral component is performed using soft tissue manipulation, myofascial release techniques and reflex balancing methods. [7] Bloodless Surgery, has been used and taught by SOT chiropractors since 1939 and was practiced much more extensively in the 1930s and 40s. Since 1960 it has been called CMRT, and focuses predominately on the vertebra and viscerosomatic/ somatovisceral relationships. CMRT is listed as a chiropractic technique throughout the chiropractic literature [15-9]. SOT clinicians using these methods of CMRT and bloodless surgery for years are beginning to publish their methods in the literature which is helping to further establish this successful method of care used for decades by chiropractors. [20-4]

Presently those interested in learning about Sacro Occipital Technique and CMRT as taught by Major Bertrand DeJarnette can attend seminars by Sacro Occipital Technique Organization– USA (SOTO-USA) and can visit the website for seminar information and research updates at www.soto-usa.org or call (781) 237-6673. Presently SOTO-USA is the only organization that is teaching CMRT specifically as developed by DeJarnette.

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REPRINTED FROM 'THE BULLETIN' SEPTEMBER 1978 BY MAJOR DEJARNETTE…. COUGHING AND THE CATEGORIES

COUGHING: (Last week all was going as well as could be expected in the office, sick were getting well and we were seeing our usual share of Category Two patients. Then we had a fellow who simply couldn't or would not cough for the SB test. He tried but to very little avail. We have struck them before and so have you. Trying to decide are they an SB+ or an SB- is a bit of a puzzle. We usually settle for an SB+ and go on. I was doing a little thinking about it all that night and tried to recall where Dr. DeJarnette had written about this very thing. So I started looking and here is what I came up with acknowledgement to M.D.J.)

You had a patient today who was a Category One and during the cough test you ran into several unusual complexities.

1. The patient could not cough. He simply didn't have a cough ability or the mechanism in working condition. That should have pointed out an investigative problem for you to solve.

2. The cough impulse must come from the cerebral cortex. Why didn't it come forth?

3. The cough mechanism is diaphragmatic. Maybe a hiatal hernia with visceral displacement was present.

4. Perhaps the patient has a degenerative disease, involving the bulbar mechanism. (I think Major is going to introduce a bulbar technique this year, perhaps it has something to do with this mechanism.)

5. The sacrum could be locked and you could have a Category Two or a Three instead of the Category One you thought.

6. You may not have paid attention enough to the heel tension test. Maybe you just pulled on the legs and measured at the internal malleoli.

7. You didn't do the arm fossa test.

8. You did the Category One with a right short leg two years ago, so you are going to do it again today, and you have not seen the patient for 22 months.

9. Let's say you had a Category One and blocked in error. That happens and unfortunately bad results are not immediate. In a Category Two you can test with the arm fossa and be sure of your blocking.

10. You jumped over the dollar and crest signs. You took them for granted.

11. You were late for the golf game or dinner or the horse races.

12. You weren't interested in the patient.

13. You, yourself, had a Category One today and assumed everyone else was with you with your troubles.

Your patient was a Category One, but you carelessly blocked him as a Category Three. You didn't observe the short leg as to direction.

THAT WILL LOCK UP THE COUGH EVERYTIME, AND THAT IS WHY YOU NEVER HAVE THE PATIENT COUGH IF A CATEGORY THREE HAS A PAINFUL SCIATICA.

15. Your patient is taking Librium as a tranquilizer. Perhaps your patient is taking Dilantin or some other such drug.

The patient does respond and coughs and you feel the bounce, or you feel the bounce and then the jerk, which is normal. Perhaps you feel the jerk and no bounce.

The bounce is SB+ or sacral dural extension. The jerk is sacral dural flexion, and is listed as SB-. So all extensions are listed as +(plus) and all flexions are listed as –(minus).

"The cough test is dramatically associated with the intracranial structures"

The sacral bounce has nothing to do with skeletal position, or sacrolumbar angulation or arthritis or spondylolisthesis. The cough test is a dural test and the response tells you what the sacral dura is capable of doing best at that moment.

The sacral dura determines the type of vasomotor subluxation your Category One patient will exhibit. The SB plus will exhibit a broader pattern of blanching while the SB minus will exhibit a petechial (spotty of freckle like) pattern of blanching.

The Sb plus tells you where to place your hand for compression as the patient undergoes traction to bring forth the stress which calls for extra blood into or out of the spinal muscles as they relate to cord circulation, and blanching results where the interference or subluxation exists. If your patient has an SB plus and you place your hand for an SB minus on the sacrum, then you cannot anticipate any reaction of a helpful nature.

All things must be done as directed and must be compatible with your corrective objective. You are the Captain, the patient's body is the ship and your duty is a safe journey from disease and pain back to health and vigour.

The cough test is dramatically associated with the intracranial structures. When the SB+ is present, the sacral dura is in extension, but the cranial dura is in flexion. When the sacral dura is in flexion (SB-), the cranial dura is in extension. This is termed the reciprocal relationship.

When both the sacral and cranial dura are in extension, the patient is in hospital hoping for help. When the sacral and cranial dura are in flexion, the patient may not make it to the hospital or get out of hospital alive. To function, each end of the spinal cord must be in opposition to the other end to function.

(ED This last paragraph is vital for understanding of how the human functions.

Continued on page 7

... CONTINUED FROM PAGE 6

De Jarnette to my knowledge is the first to have a total understanding of this respiratory function and the ability to communicate that understanding to mere mortal such as ourselves. Dig out the 1978 notes and open it up at page 119 and start to study and understand the significance of the physiological function of the dura. It should be noted however that this last paragraph refers specifically to dural function and not to motion of the cranial bones in respiration as these have the opposite motion for correction or listing purposes.)

A patient with a terrific migraine probably has the sacral dura in 60% extension and the cranial dura in 40% extension. There is a 20% help factor here. By giving the patient medication that puts him to sleep, the body can relax in it's tension fields and this helps return, TEMPORARILY the dural function to a state of semi-balance.

The S.O.T.'er examines this patient and categorizes him properly and applies the Category blocking indicated. You must remember that the Category Two locks the sacrum and can be a terrible offender if the sacrum locks under the wrong degree of tension at the dural insertions. The blocking, whichever Category it may be, relaxes the dura because its work load is eased off. This permits a reciprocal relationship to take place and eventually the migraine problem is solved providing the patient permits time to intervene, for there is no hope of a spontaneous cure.

When you bend forward to pick up an object from the floor, you are said to be in a state of flexion. When you bend backward to watch an aeroplane overhead or to look at a tall building, you are said to be in a state of extension. Flexion bends...extension straightens, if you believe Dorland and Webster.

The cough tests for dural flexion and extension as a part of the Category One procedure relate to the Primary Sacral "Respiratory Mechanism. The S.B. plus or minus cough test in totality is relative only to the Category One and the exact blocking position. This blocking position is the only mechanical means we have of physically altering the extension or flexion factor as it relates to the dura.

We saw a grade 4 spondylothesis some days ago, who would be all the rules of skeletal anatomy and physiology be a SB plus, but was a specific SB minus. Blocking for a Sb plus increased his pain immediately. Blocking for an SB minus controlled his pain immediately but did not affect the lumbar five anterior slippage, neither did it correct the pars-articularis separation.

Heel tension is dramatically associated with the cough test. Heel tension is a tendon guard reflex which stabilises the atlas vertebra. If the heel does not lock, the atlas will not remain aligned or pressure free. Nothing in the human body is more dramatically related than is the heel tension and the atlas position. The tendon guard reflex is a dramatic reflex and if you will study and apply this as taught in SOT you can immediately select your Category patients by the bilateral difference in prone testing for heel tension.

The Category Two or Three does not need or have the tendon guard reflex. The Category One has the need for the tendon guard reflex and if this Category One is to remain ambulant, they better lock that heel in until some D.C. can block properly and remove the need for the tendon guard reflex.

Those who adjust the atlas specifically recognise the vast importance of the feet and heels and the relationship to atlas.

When you place all sorts of mechanical things in patient's shoes to support the feet, often times you subluxate the spine. WATCH OUT.

Author

REFERENCES

Just in case you didn't get the message

The venue for the

2006 Annual Convention and Annual General Meeting is now called

Citigate Melbourne Hotel

270 Flinders Street Melbourne

Phone 03 9654 6888

Formerly the Ramada Melbourne

CRANIAL OSTEOPHATHY: IT'S FATE SEEMS CLEAR - CONT'D

170),17 (p144-147),18-21], quantum mechanics [16(p55-56),17(p137-138),19], vitalism [17(p141-147),19,22(p14-16),23], or God [16(p123-124)].

So the Primary Respiratory Mechanism is gone and there is no evidence of efficacy . . . but cranial osteopathy/craniosacral therapy, as a belief system, soldiers on. What could be, at most, a placebo, is aught--as medicine--in all colleges of osteopathic medicine in the U.S. [3], is tested for—as medicine--on osteopathic licensing examinations in the U.S. [13], and is practiced—as medicine--around the U.S. and abroad. Practitioners of the "cranial" arts all may be caring, otherwise competent physicians—and some are close friends--but they have hitched their professional wagons to a fantasy and are understandably reluctant to disengage.

As a scientist in this age of evidence-based practice, I have grown frustrated in my dealings with the "cranial" faithful. As a group, evidence carries little weight with them. In our own professional community, skepticism has drawn rebuke and charges of disloyalty, rather than reasoned debate--but I was not surprised. Early in my study I concluded that cranial osteopathy is a pseudoscientific belief system, maintained--by both patients and practitioners--through operation of well- and widely understood principles of human personal and social psychology.

From that standpoint, practitioners simply have defended passionately held views to which they long have been committed. Cognitive dissonance [24] inspired by our disbelief brought exactly the reaction we anticipated. Although I remain hopeful that practitioners and healthcare disciplines wedded to these techniques—especially osteopathy—soon will let evidence guide policy, responsible action will not come without trauma. Cranial osteopathy has so long maintained its place in the osteopathic fabric that great personal and political courage now will be required to remove it.

Summary

After millennia as socially sanctioned, organized magical thinking, medicine has become a powerful service profession. This transition was possible only because scientific inquiry has become integral to almost everything physicians do. Without science, medicine would still involve little more than applying tourniquets, setting bones, and administering placebos. Cranial osteopathy/craniosacral therapy is not a medicine for this century. Perhaps properly controlled outcome studies will show that, though biologically anomalous, these techniques nonetheless produce a direct and positive effect on patient health. Until they do, however, the "cranial" arts should be dropped from all academic curricula; insurance companies should stop paying for them; and patients should invest their time, money, and health in treatments grounded in the extraordinarily successful, science-based biomedical model of the modern era.

Competing interests

I have taught at the same college of osteopathic medicine for 20 years. Ordinarily, this might prompt suspicion that I have not been openly forthcoming in my criticism of osteopathy's "cranial" subdiscipline. To the contrary, some members of my professional community have

questioned my loyalty, apparently believing that my views might have a negative impact on the college or the osteopathic profession. Otherwise, I declare that I have no competing interests.

For a full list of References go to the below link

http://www.chiroandosteo.com/content/14/1/10

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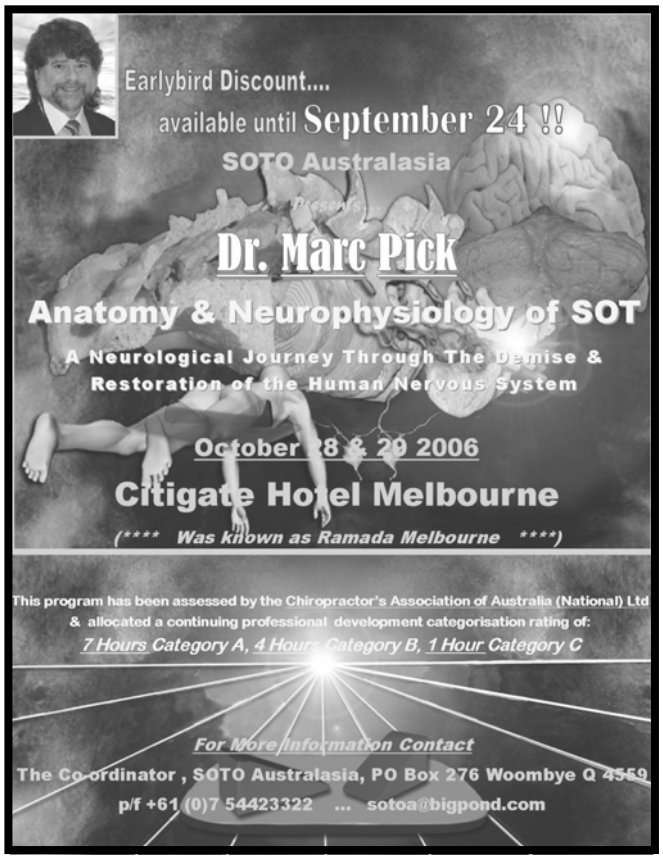
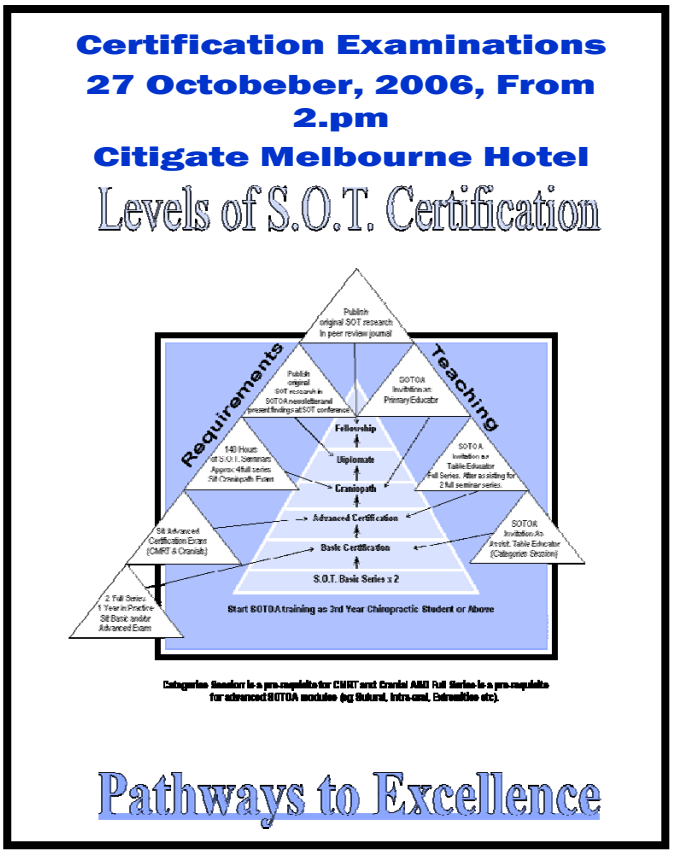
LIST OF REFERENCES

The Evolution of Bloodless Surgery and Chiropractic (page 5)

1. Last RJ, Anatomy: Regional and Applied, Sixth Edition, Churchill Livingstone: New York, 1978:20.
2. Keating JC James F. McGinnis, D.C., N.D., C.P. (1873-1947): Spinographer, Educator, Marketer and Bloodless Surgeon Chiropractic History , 1998; 18(2): 63-79.
3. DeJarnette MB, Technique and practice of bloodless surgery, Privately Published, Nebraska City, NB, 1939.
4. Taylor H, Sir Herbert Barker: Bone-Setter and Early Advocate of "Bloodless Surgery" Journal of the American Chiropractic Association 1995 Jul; 32(7): 27-32.
5. DeJarnette MB, Chromotherapy, Privately Published, Nebraska City, NB, 1941.
6. DeJarnette MB, Chiropractic Manipulative Reflex Technique, Privately Published, Nebraska City, NB, 1964.
7. Blum CL, Monk R, Chiropractic Manipulative Reflex Technique, Sacro Occipital Technique Organization – USA, Winston-Salem, NC, 2004.
8. Budgell BS., Reflex effects of subluxation: the autonomic nervous system. J Manipulative Physiol Ther 2000 Feb;23(2):104-6
9. Budgell BS, Spinal Manipulative Therapy and Visceral Disorder Chiropractic Journal of Australia 1999 Dec; 29(4): 123-8
10. Sato A The reflex effects of spinal somatic nerve stimulation on visceral function. J Manipulative Physiol Ther. 1992 Jan;15(1):57-61.
11. Seaman DR, Winterstein JF, Dysafferentation: A Novel Term to Describe the Neuropathophysiological Effects of Joint Complex Dysfunction. A Look at Likely Mechanisms of Symptom Generation Journal of Manipulative and Physiological Therapeutics. 1998 May; 21 (4): 267-80
12. Szlazak M, Seaman DR, Nansel D, Somatic Dysfunction and the Phenomenon of Visceral Disease Simulation: A Probable Explanation for the Apparent Effectiveness of Somatic Therapy in Patients Presumed to be Suffering from True Visceral Disease, J Manip Physiol Therp. 1997 Mar;20(3) : 218-24
13. Dvorak J, Dvorak V, Manual Medicine: Diagnostics, 3rd Edition, (Translated from German) George Theime Verlag, Stuttgart, Germany, 1988: 326-33
14. Heese N, Viscerosomatic Pre- and Post- Ganglionic Technique, Am Chiro, 1988 Mar :16-22.
15. Peterson DH, Bergman TF, Chiropractic Technique: Principles and Procedures (Second Edition) Mosby: St. Louis, MO, 2002: 493, 497
16. Gleberzon BJ, Chiropractic 'name techniques': a review of the literature European Journal of Chiropractic 2002; 49: 242-3.
17. Gleberzon BJ, Chiropractic "Name Techniques": A Review of the Literature J Can Chiropr Assoc 2000;45(2): 86-99.
18. Bergmann TF, Various Forms of Chiropractic Technique ,Chiropractic Technique May 1993; 5(2):53-5.
19. Cooperstein R, Gleberzon BJ, Technique Systems in Chiropractic Churchill Livingstone: New York, NY April 2004: 209, 211, 214, 217.
20. Courtis G, Young M, Chiropractic management of idiopathic secondary amenorrhœa: a review of two cases British Journal of Chiropractic Apr 1998; 2(1):12-4.
21. Cook K, Rasmussen S, " Visceral Manipulation and the Treatment of Uterine Fibroids: A Case Report ", ACA Journal of Chiropractic Dec 1992; 29(12): 39-41.
22. Blum, CL, Role of Chiropractic and Sacro Occipital Technique in Asthma Chiropractic Technique, Nov 1999; 10(4): 174-180.
23. Blum CL, Chiropractic care of diabetes mellitus? A Case History Journal of Vertebral Subluxation Research, Accepted for publication April 2003.
24. Blum CL, Resolution of gallbladder visceral or mimicry pain, subsequent to surgical intervention, International Research and Philosophy Symposium Sherman College of Chiropractic, Spartanburg, SC, Oct 9-19, 2004: 10-11.





HIATUS HERNIA & S.O.T. CONT...

Flatulence The patient will have so much gas at times which can become so severe that the clothing will have to be loosened.

Colourless Face The patient will evidence a lack of normal colouring in the face, due to the lack of oxygen resulting from restricted and shallow breathing.

Causes

The term hiatus comes from the Latin meaning 'window! So we have a window in the diaphragm whose sole purpose is to allow the hollow musculomembranous canal, or the oesophagus to carry food from the mouth to the stomach (Oesophagus from the Greek, comes from two words 'to carry' and 'food').

Causes suggested for the malposition of the stomach are a direct blow to the stomach, landing on the stomach while making a dive or a severe and heavy lift but as SOT practitioners, we need to examine cause mechanisms in terms of the craniosacral mechanism.

At some time, a slip separation of the weight-bearing portion of the sacroiliac joint has occurred. The instability of this Category II situation invokes imbalance in the psoas and latissimus muscles and a diaphragm imbalance ensues, which sets the stage for the oesophagus stomach interface or gastric antrum to rise. (Diag. 1 & 2)

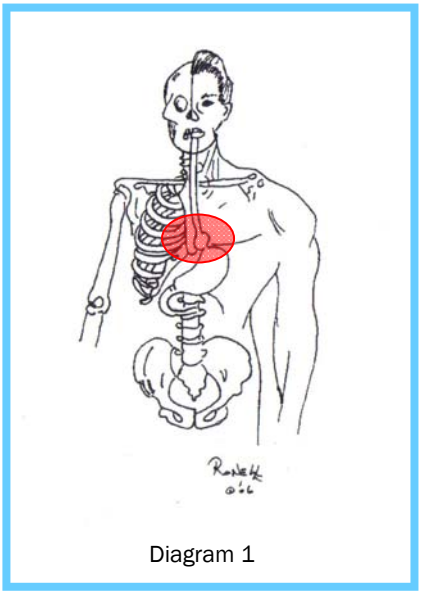


Diagram 1

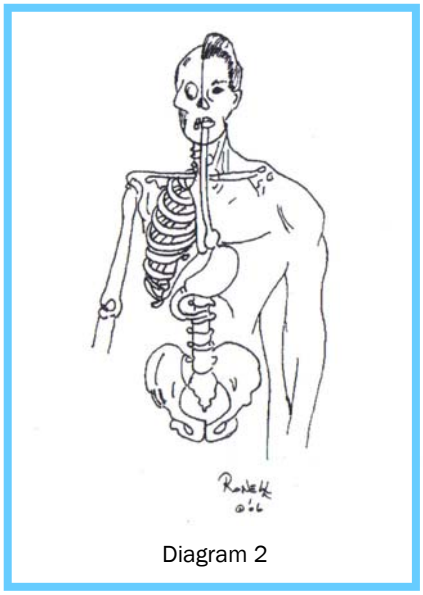


Diagram 2

The anatomy of the stomach valves is governed by survival factors. The lower valve, the pyloric valve is a strong valve which prevents matter from returning to the stomach. The cardio oesophageal valve is purposefully weak to allow vomiting (this valve hardly receives a mention in some anatomy texts). While this ensures you don't die the first time you eat a piece of 'bad pork' from the takeaway, it means as a trade-off, you can develop an HH.

Adjustments

Several techniques to help the hiatal hernia have been developed including two methods by De Jarnette, those offered by Byron White and Ralph Failor and the method popularised in SOT by Dr Rees, known as the Allen flip which is taught currently in the basic series by SOT A/Asia.

The term CMRT, Chiropractic Manipulative Reflex Technic is a term used by De Jarnette from the 1960s. Earlier works such as those from the 1930s, 1940s and 1950s were known as Bloodless Surgery. From the 1936 Volume of Bloodless Surgery entitled "Reflex Pain" comes the first technique for hiatus hernia, De Jarnette suggested sitting behind the patient encircling the patient's body and lifting the entire ribcage ceiling-ward. This freed the 'stuck' lower end of the oesophagus so that it could move freely with respiration (10). (This works but it's a bit like holding the light bulb still while you get those fifty Celtic gentlemen to turn the house).

De Jarnette's more recent approach can be found in either of the last two printed SOT manuals (we have often referred to these final two SOT manuals in this series of articles. The final edition SOT 1984 is available at the seminars or through SOT Australasia).

The De Jarnette Technique:

The patient's left hand is made into a fist and placed over the gastric area just inferior of the sternal xiphoid process, the palm side next to the skin. Doctor's contact is a flat hand laid over the patient's closed fist and that hand is supported by the doctor's free hand.

The adjustment is performed with consideration of the respiratory' cycle, thus, both Doctor and patient can inhale together. When inhalation is in process, pull down slightly onto the patient's closed fist and hold for five seconds; patient exhales and so does the doctor. Patient inhales alone, deeply as the doctor continues to pull posterior and slightly inferior.

HIATUS HERNIA & S.O.T. CONTD...

The Thrust

The doctor then releases his contact, patient inhales deeply, while doctor now moves patient's closed fist firmly against sternal xiphoid. With Doctor's hand pressure onto patient's hand, patient exhales rapidly and with force as doctor hives a quick thrust posterior at termination of exhalation (11).

Dr Byron A White's techniques are credited to his associating with Viennese Orthopaedist, Dr Adolph Lorenz. By way of background, at the beginning of the twentieth century, orthopaedists and gynaecologists in Germany, France, Austria, Sweden and other European countries were very familiar with the manipulation of the body's soft tissues; Dr Lorenz was one of Austria's leading Bloodless Surgeons of this time. On one of his visits to America he taught the work to Oregon Chiropractor, Dr Byron White.

Dr Ralph Failor associated with Dr White and described the work in 'Three generations of Healing Secrets' (1975).

The Failor Technique:

A similar contact as that shown at SOTO Australasia Seminars to contact the hiatal area is made, that is, one hand usually the right, overlaid and reinforced by the left hand with the fingers cupped. White and Failor started with a sweeping, circular movement going very lightly and gradually increasing with the purpose of relaxing the abdominal muscles in a preparatory manner.

Then with the slightly curved finger tips of your right hand, reinforced by the fingertips of the left hand contact the lesser curve of the stomach, which will be positioned quite high, exert a light but deep pull straight forward for two inches (5 cm) and then continuing with your move, curve it slightly to the patients left side, just below the costal margin for another inch or two.

Failor suggested following the correction with a method he termed 'Ballooning the stomach'. This is performed by placing the heel of the right hand on the lesser curvature of the stomach and once again the left hand reinforces the right and making a few clockwise rotary thrusts to reinforce the earlier correction, (12)

Also Dr M L Rees is known for his tempero-sphenoidal work, the palpatory tender areas that can be used as a way of verifying findings with the occipital fibre analysis.

The Allen flip technique came to SOT practitioners from Dr Leonard J Allen of Margate, Kent who had visited Dr ML Rees in the late 60s to learn the TS work. In discussing and exhibiting techniques, Dr Allen shared his 'stuck oesophagus' technique which Dr ML Rees demonstrated at SORSI's Omaha homecoming in 1969. (13)

The Allen Technique:

You go in under the xiphoid with both hands overlaid (in a similar manner to Failor's Technique) as the patient takes three deep breaths. You are gaining and holding your contact on each breath. At the end of the third exhalation you simply let go as you flip your fingers out. This elicits ligamentous stretch reflex and causes immediate recoil for the antechamber of the stomach to retain its motility.

Dr Allen suggested an alternative approach to the flip technique. A Racketball, placed in the palm of your left hand and reinforced by your right hand is used. The grip of the ball is, in our experience, quite effective in attaining the 'drag' needed especially with those patients possessive of tight diaphragmata (14)

In conclusion, we have discussed several variations to the HH correction. The common theme, as is the case with all bloodless surgery type methods is to go gently. The important thing is the De Jarnette comment to not exclude this most valuable approach to your daily patient care.

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References

1. SOTO Australasia Seminar notes 2006
2. De Jarnette MB SOT 1984
3. Failor RM Three Generations of Healing Secrets -
4. De Jarnette MB SOT 1983
5. De Jarnette MB SOT 1984
6. Dr. Rees ML Sorsi Despatcher 1974
7. Dr. Rees ML Sorsi Despatcher 1974
8. Failor RM Three Generations of Healing Secrets
9. Failor RM Three Generations of Healing Secrets
10. De Jarnette Reflex Therapy 1936
11. De Jarnette SOT 1984
12. Failor RM Three Generations of Healing Secrets
13. Dr. Rees ML SORSI Despatcher 1974
14. Dr. Parker Scott, Personal correspondence 2006.

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'Locum/Associate available in Sydney. 2005 graduate. Techniques include: SOT, NET, AK, Acup, Diversified, TRT. Please contact Luke on 0403 947 063.

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