SOTO AUSTRALASIA

WINTER 2005

EXPRESSION

MAY, 2005

THE CATEGORY II

INSIDE THIS ISSUE:

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One of the things we've seen over the years in SOT is a chiropractor who will do the seminar series and not practice SOT, yet, the person next to them get the idea of the indicators and systems-based approach to DeJarnette's work and goes on to practice it standardly. The difference we have figured lies in grasping the fundamentals. Basics Basics Basics!

The first thing we learn in SOT is the Category II. Anyone who has been a practitioner for a while knows how prevalent this is and also, how great a response can be gained from following a standard SOT Category II protocol.

In this article, we will outline how DeJarnette developed his understanding of the Category II. It did take many years of practice and enquiry and it did challenge the status quo of chiropractic thought up to its full realization in the late 1960s and early 1970s; with, of course, other viewpoints on the nature of pelvic distortion continuing today in our chiropractic colleges.

In our SOT seminar notes from SOTO Australasia, we learn about the two main parts of the sacro-iliac joint – the upper weightbearing and the lower boot part of the joint each with a different nature and function.

DeJarnette has suggested that his introduction to the sacro-iliac joint and its dysfunction was in 1935. In a letter to the June 1984 SOTO A/Asia bulletin he stated:

"The Osteopaths used to try to adjust the innominates as a total bone with some results. The first article I saw describing the boot and the hyaline part was in the Nebraska Osteopathic Journal in 1935. They did not approach it as two separate entities as we do in SOT." [1]

One thing is for certain, Anatomists cannot agree as to the nature of its joint, its function and thus its clinical significance. Historically, Albinus and Hunter were the first anatomists (in the 18th Century) to describe a synovial membrane lining the joint. In the nineteenth century, Von Luschka (1864) stated that the SI joint was a true diarthrodial joint. To the twentieth century where we had several opinions as to the nature of the SI joint including Braus (1921) – Amphiarthrosis; Rauber and Kopsch (1940) – an intermediate joint having synarthrotic and diarthrotic characteristics and Tetstut and Laterijet declaring it to be partly amphiarthroidal and partly diarthroidal (as it is understood in SOT) [2].

DeJarnette's approach was to observe and determine clinical findings and then to correlate these findings with the anatomy. In the 1942-44 period, he noted that a large group of his patients presented with upperfossa tenderness, and medial knee tension on the side of the short leg. [3] Interesting, but what did it mean? During this time, this presentation was known as an 'innominate meningeal lesion' (the term Category II not appearing until the 1960s). That his understanding that this lesion was a 'separation' of the joint rather than a 'fixation' is evidenced by his adjustment methods of the 1940s and 1950s.

In this period, DeJarnette's side-posture adjustments consisted of compressing the upper pelvic lesioned side, followed by the long leg, ischium side i.e., no thrust. Read the 1957 manual for a full description and note that by 1967, the Category II as we know it today had evolved but was not fully standardized until 1976. (The early 1970s saw the establishment of the arm fossa test as a superior method of determining and monitoring the Category II – a topic for one of our future articles.)

PRESIDENT'S REPORT

DR BRETT HOULDEN

What an exciting year it promises to be for SOT in Australia and New Zealand. Memberships continue to be strong, and we have some great seminars coming your way. Our basic series has kicked off with Townsville and Melbourne going well, Sydney to come shortly, and New Zealand in July.

We have two exciting extra-special events this year. When we polled our members who they wanted to hear more of in the future, three names were very prominent: Drs Steve Williams, Jonathon Howat and Marc Pick. So, it is great to announce that we have Dr Steve Williams and Dr Jon Howat coming this year, and we are chatting with Dr Marc Pick to come out here in October next year.

Steve, back by popular demand, will do another enlarged paediatric seminar. It is once again aimed at the profession at large, so bring along your non-SOT friends, all at the Gold Coast, 9th and 10th July. He is still the best paediatric presenter I have seen, and he is bringing out some new material, and speaking for more hours, one weekend not to miss.

Dr Jonathan Howat will be the keynote speaker for our Annual General Meeting on 29th and 30th October. His presentation is all about how a new cranial procedure which is very exciting and will be a very useful adjunct to any SOT / Cranial repertoire. In essence, it is all about the "Descending Cranial Major", and how to change the cranial dural torque. It will put you the cranial chiropractor back in control of this pattern.

As your president, I get the opportunity to work with many people who do lots of work. I would like to thank Averil and the entire board for their tireless work. Thanks also to Dr Scott Wustenburg our new newsletter editor, what a wonderful job he is doing. They do us as an organization proud, and are a large part of why you have such a wonderful organization.

We are always keen to hear your feedback on any issues, feel free to drop me a like at bretth@netcon.net.au or phone me for a chat.

Enthusiastically Yours,

Dr. Brett Houlden.

THE CATEGORY II (CONTINUED)

Back to the controversy over the SI joint. It is clear from reading other chiropractic and osteopathic manuals that the concept of weight-bearing upper part and fibro-cartilage covered, synovial fluid-protected lower or boot part is not grasped.

DeJarnette reminds us that 'In the Category II, you must remember that the hyaline cartilage covers the articulation that is immoveable until sprained, strained or forcefully opened by trauma. If the weight-bearing part of the sacro-iliac joint were moveable in the adult, we would walk like ducks" [4]. And that: 'The Category II is not a candidate for the side position or the lumbar roll or the so-called innominate side posture technique. These may appear to help but they simply transfer the problem to some other body part'. [5]

The final word: "The innumerable subluxations listed by some techniques in relationship to the pelvis is exaggerated to say the least, and unprovable in 95% of all such instances. It would be pretty difficult to superimpose a stress upon the human body in the erect posture that would drive the ilium inferior of the sacrum, yet this is a listing of some techniques. It is pretty difficult to develop a theorem that would prove it possible to rotate the ilium in such a manner that it would actually flare out or in and thus separate or constrict an immoveable union without totally and permanently disabling the patient so afflicted, yet this is a common listing in some techniques. It is quite difficult to imagine three bones and two unions capable of thirty two subluxations, yet I read that such was being taught in one technique. Suppose all thirty two subluxations happened at once. Some Mess!" [6].

John S. Kyneur, HABERFIELD, NSW

Peter J. Kyneur, TORONTO, NSW

Like to teach? "Certification can be sat on October 28 at the *2005 Annual Convention*

FROM THE EDITOR'S PEN

Here's an exciting new edition. Much has changed since I last wrote to you. My apologies on the delay, I have changed countries completely and am now in Brisbane. I have done so in search of new education and new opportunities as I spoke to you about in our last Editor's Pen. I implore you all to assess yourselves to determine if you are in a rut. Perhaps one of this year's seminars such as Steve Williams or others might make the difference. New connections, new information, new opportunities.

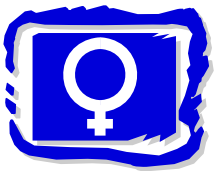
Have a great winter

HRT—THE WHOLE STORY

DR. PAUL EATHER

The purpose of these notes was to try and discover for myself some of the discrepancies that exist between 'HRT' and health. It is by no means a definitive article on the subject, rather it's aim is to expose some of the myths behind the whole concept of hormone replacement therapy to help you inform your patient's about their health and what may be being forced upon them by medicine and the pharmaceutical industry.

My hope is that if your interest is sparked you yourself will be motivated to continue your voyage of hormone discovery or at the very least you will feel more empowered to deliver to those who need it, some of the truths as to why the current method of testing and prescription is at the very least inadequate, or simply put, very deadly.



There are several things that need to be considered when beginning to look at the whole industry of Hormone Replacement Therapy

Firstly, it should be remembered that progesterone is the precursor to all the other steroid hormones. (1)

Secondly, all hormones are derived from cholesterol and therefore are very fatty in nature.

Thirdly, there is no such hormone as oestrogen. Just is there is no such 'car' called 'car', there are Holden's and Ford's and Mitsubishi etc. The main hormones in the oestrogen class that we are interested in are estrone, estradiol, and estriol. There are some 20 – 30 in total in the oestrogen group.

As with anything, synthetic analogues can in no way have a beneficial effect on the human system.

Menopause is described as "The physiologic cessation of menses as a result of decreasing ovarian function. It is a retrospective diagnosis, made when menses has not occurred for a year. Menopause may be natural, artificial or premature." (2)

When 'menopause' occurs oestrogen does not 'dry up' in the female body. Instead it lowers the amounts in the system to prevent the monthly shedding of the lining of the uterus.

By this time the body has determined that the need to have children is no longer viable and therefore this monthly ritual need not occur and so steps are taken to prevent it from happening. Your innate intelligence knows just how much to lower the hormone levels. Your estrone levels decrease by about 40% and estradiol by approximately 60%.(1)

Remembering the above points, lets begin to look at the blood test. Delivered by the local G.P., this is an incorrect way to measure hormones and where the whole medical cycle regarding hormone replacement begins to come undone. When blood is taken and sent to the lab, it is placed in a centrifuge. The purpose being to separate the watery and the fatty part of the blood. The technician then looks into the watery part of the blood to see what concentrations of the hormones can be found to determine the results. As you will have read above, hormones are fatty! The hormone (in its natural active state) will not ride in the watery part of the blood.

The question most often asked at this point is, "If that is the case how come they find hormones in blood then?" The reason is due to the body's intelligence and the role of the liver. Once the hormone is no longer viable in it's role within the cells, it is coated by a water-soluble protein by the liver in readiness to be excreted from the body via the kidneys.(1) Therefore, **what is actually found in the blood is of no value to the technician because it is no longer biologically active.** What we really need are measurements of **biologically active hormones** because they will be causing change and effecting the system.

Armed with this physiological knowledge that it is the oestrogens that cause the bleeding to occur, it concerns me that a 40 year old female will present to the medical authorities with some 'symptoms of menopause' whilst still having a period and be told she needs to take an oestrogen supplement.

INSIDE STORY HEADLINE

Natural progesterone and the ability to derive it from plant sources has been available to the world at large since the 1930's. This is thanks to the work done by Russell E. Marker. He discovered how do get progesterone from the plant source and instead of patenting his discovery, he gave it to the world, free of charge so that science could benefit mankind.

The beneficial role of progesterone has been acknowledged for a great many years. Most forms of progesterone are derived from plant sources and replicate exactly, the role of human progesterone. The problem is that you can't patent a natural product and therefore there is no money to be made. Still, progesterone is necessary for hormonal health. The pharmaceutical industry just had to find another way.

The pharmaceutical companies hit upon the idea of synthetic analogues of progesterone. As with anything synthetic, it can in no way have a beneficial effect on the human system.

When you change one part of the molecular structure, that molecule can no longer have the same effect its natural counterpart. The chemical structure of medroxyprogersterone, closely resembles the chemical structure of progesterone as it is produced naturally in the human body. But, even a slight difference in the molecular configuration of a compound can produce a totally different response from its natural counterpart. (6).

Medroxyprogesterone is commonly known as Provera and is synthesised from pregnant mares urine.(1) The concept that oestrogens and progesterones coming from horse placenta's created in the laboratory will have positive long-term benefits in the human female simply makes no sense. (5)

Another immediate difference between medroxyprogesterone and natural progesterone is that the synthetic hormone can actually lower a patient's blood level progesterone. Some women who take medroxyprogesterone to combat PMS or oppose oestrogen in menopause report headaches, mood swings and fluid retention. (6).

Progestins have side effects such as acne, menstrual irregularities, migraines, striae, weight gain, depression, mood swings and irritability (4).

As it turns out, a saliva test is the most accurate way to secure the right result. Blood goes into the fatty tissue of the saliva glands, which pick up the real hormone. Saliva made by gland carries the same amount of the hormone because the saliva is not water, it is a mucopolysaccharide and it absorbs hormones directly from the tissues, so when you do a saliva test, you are measuring only the 'real' hormone. (1)

Believe it or not, this technology has been around for over 20 years.

In today's society, oestrogens are prevalent. They can be found in meat, grain, pesticides, margarines, salad dressings, insect sprays, herbicides, plastics, cars and carpets, cosmetics, shampoo's and conditioners, to name but a few. When this added to what the body has naturally occurring, it is no wonder that we usually end up with excessive oestrogen levels rather than diminishing amounts of oestrogen.

Compounding this problem is that environmental factors now keep 'topping up' the oestrogen levels so that this natural decrease in hormones cannot occur as nature intended. Instead the body is forced in to having to deal with an influx of oestrogens at a stage when oestrogen should be at lower levels or regulated to match that persons stage of life. Instead, more problems begin to arise. This is one of the main reasons I believe that the L5 Uterine C.M.R.T reflex can be so hard to negate.

The most destructive of the these environmental groups are called xeno-oestrogens and their biggest problem, aside from being poisonous is that the body can't excrete them. Xeno-oestrogens have also been shown to disrupt cellular activity and actually damage D.N.A. Xeno-oestrogens cause stress within the body and this causes the body to produce more cortisol. In turn, this cortisol increase not only occupies the exact receptors as does progesterone, downgrading the bio-

XERO-OESTROGENS HAVE BEEN SHOWN TO DAMAGE DNA

If DNA can manage to make perfect arteries for 500 centuries, there is no intrinsic reason why your DNA should botch the job after 60 years."

Deepak Chopra

HRT—THE WHOLE STORY Cont...

available amount in the body, it also seems to reduce the bodies production of progesterone.

Some debate has also centred around phyto-oestrogens which are derived from plant sources like the soya bean. Phyto-oestrogens seem to have a milder more natural oestrogenic effect and they also occupy oestrogen receptors in the body, limiting the amount of zeno-oestrogens that are able to affect cells and disrupt DNA. This above view is primarily medical in nature and would seem to go against some of the latest information on human nutrition. At this point, it would appear that the jury is still deliberating the role of phyto-oestrogens.

The ratio of progesterone to estradiol should be 300. Most women on HRT are therefore being overdosed (on oestrogen) 8-10x. (1) It is truly a testament to the body that it can survive for so long under a continual and deliberate poisoning.

It is apparent to me that HRT as it is known and used to today is physiologically incorrect, devoid of common sense and immoral. At the very least we need to be able to offer to those using our services decent answers and the possibility of a healthy future.

I would encourage you to read more on this subject because the correct answers already exist and are not that hard to find. We owe to ourselves and others to make sure that we, as health care practitioners have these answers available.

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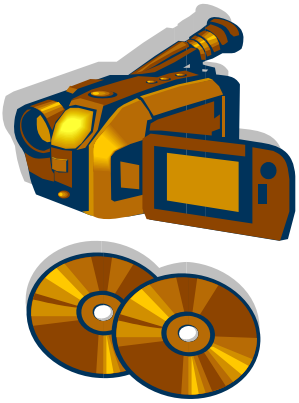
Paul Eather

Castle Hill, Sydney



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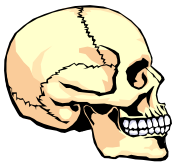
2005 ANNUAL CONVENTION & AGM



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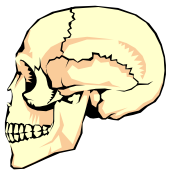

SOTO AUSTRALASIA AGM

Saturday 29 October, 2005—5.30pm

Certification Examinations 2.00pm Friday 28 October, 2005

CHIROPRACTORS, DENTISTS AND THEIR CRANIAL CONNECTION …. PART 2

By Dr Tony Simeone

Spinal Lordosis and Cranial Sutural Locking

In a normal occlusion the upper incisor teeth should not contact the lower incisors during swallowing or chewing but forced retrusion results in continued occlusal interference from the incisor teeth eventually causing a chronic forward head posture. This changes the cervical spine lordosis at the level of C3, C4 and C5 inducing an anterior curve which may result in degenerative changes at those levels.

The anterior head tilt results in spasm of the temporalis muscle. The temporalis covers most of the sutures of the lateral aspect of the cranium and as the muscle continues to spasm the cranial bone sutures beneath it lose their mobility, or lock. The natural cranial bone motion is inhibited and so is homeostasis.

Arch Expansion

Ideally, dental and cranial clinicians would like to treat the arches of the maxilla and mandible toward achieving the arch shape and size found in primitive man. However, full complete arch expansion cannot be accomplished once the bones of the skull have completed their growth in size and shape. But, Dentists can attempt to permanently modify the size and shape of the dental arches of most patients, thereby approaching ideal symmetry. The amount of expansion achievable is dependent on the size, shape and mobility of the rest of the facial and cranial bones.

For many years the technique of developing arches in growing children has been successfully used and the application to adults is improving but limited. In treating severely compromised cranial and dental patients, expansion of the dental arches of adults may be required for best clinical results. If an adult patient has had prior extraction of bicuspid teeth, expanding the dental arches will result in "opening up" the extraction sites resulting in the need to place prosthetic teeth in those spaces.

Early diagnosis and treatment of deficiencies of the Cranio-Dental Complex in children should be the goal of every dental and cranial clinician. This will require abandoning many of the traditional orthodontic diagnostic and treatment methods and embracing functional orthopaedic techniques.

Wisdom Teeth Extraction

As the orthodontically treated children who had bicuspid extractions become adults the wisdom teeth appear between ages 18 and 25. Because the dental arches are underdeveloped and retractive orthodontic forces have utilized any posterior arch spaces, these third molars are quite often impacted and fail to erupt adequately so they too are extracted. This being the case then 25% of the natural dentition has been re moved by early adulthood for the sake of straight front teeth.

These patients tragically may require a full reversal of their earlier treatment with expansion of upper and lower arches, protruding of the mandible, erupting posterior teeth and replacement of the missing bicuspids.

Loss of Posterior Support

Loss of posterior support may occur as a result of the tooth loss and over a period of time, will create an imbalance and impaction of one temporomandibular joint and distraction of the other. Damage to the retrodiscal tissues results and jamming of the temporal bone which drives the malocclusion. These types of malocclusions affect the anterior pivot at the maxillae-sphenoid junction. This is a major descending stress pattern that needs to be addressed prior to any changes made to the cranial vault.

Temporo Mandibular Dysfunction

This can be caused by a pelvic problem, a cranial problem or a dental/cranial problem. A wide range of seemingly unrelated symptoms can be produced as result of structural and functional anomalies in the relationship between the maxillae and mandible and the relationship between condyle to glenoid fossa. The scope of this subject is wide and warrants further consideration. Commonly symptoms can be in

The Eyes pain behind the eyes, bloodshot eyes, bulging eyes, sensitivity to light, photophobia and disturbed vision. Typically, spasms of the pterygoid muscles on the pterygoid plates will disrupt and alter the position of the lesser wing of the sphenoid bone affecting the superior orbital fissure. This may affect Cranial nerves III, IV, V and VI. These muscle spasms may also constrict the maxillary artery which results in reduced blood supply to the orbit and subsequent visual disturbances. The visual aura preceding some headaches may be caused in this way.

The Jaws symptoms include clicking and noisy jaw joints, pain in and around the jaw joints and ears, pain in the cheek muscles and uncontrollable jaw and tongue movement. Pain is the usual consequence of muscle spasm which affects the relationship of the condyle in the glenoid fossa, the articular disc, the delicate retrodiscal tissues and the articular eminence.

...Continued from our last Newsletter

"Early diagnosis and treatment of deficiencies of the Cranio-Dental Complex in children should be the goal of every dental and cranial clinician."

Continued overleaf...

BY DR. TONY SOMEONE ... CONT. FROM PAGE 4

The Head headaches can take the form of frontal, temporal, parietal and occipital. Muscle spasm leading to restriction of cranial motion and sutural locking affects the endosteal dura and will ultimately affect venous drainage which may create zones of hydrostatic pressure change in the cerebrospinal fluid within the cranium.

The Face symptoms include facial neuralgia, tic douloureux and Bell's palsy. Temporal bone changes may alter the internal acoustic meatus which carries the facial nerve (CN VII) and the vestibular cochlear nerve (CN VIII). This can affect the facial muscles, facial function, eyelid function, hearing and balance.

The Throat symptoms include swallowing difficulties, hoarseness, laryngitis, voice irregularities, constant clearing of the throat, coughing and the persistent feeling of a foreign object in the throat. A retrusion of the mandible will cause a change in the tone of the digastric, geniohyoid, mylohyoid and sternocleidomastoid muscle affecting the oesophagus, trachea, larynx and pharynx.

The Neck symptoms include stiffness, muscle spasms, shoulder girdle and upper trapezius pain and paraesthesia into the arm and fingers.

The Teeth occlusal changes will alter the lines of force through the teeth, producing damage to the cusps. Premature contacts and occlusal interferences can lead to excessive pressure with subsequent loosening of the periodontium and alveolar bone loss.

Interdisciplinary Treatment Approach

A major descending stress area is primarily a dental problem that needs chiropractic support to ensure a return to biomechanical stability. A major ascending stress is primarily a chiropractic problem requiring dental reinforcement to ensure that premature contacts of teeth, loss of dentition and occlusal interferences can be monitored while the sacroiliac lesion is stabilized. The interdisciplinary cooperation between a chiropractor with cranial skills and a dentist/orthodontist indicates that with effective teamwork between the two disciplines the required results can be achieved.

Initially the Dentist must ensure there is adequate TMJ health prior to any dental orthopaedic or prosthetic changes can be made. Once the Dentist has provided a stable condyle to fossa relationship there will be stability at the anterior cranial pivot which will allow the chiropractor to initiate structural changes to enhance the craniosacral mechanism and stabilise any sacroiliac lesion. Once this is achieved the patient enjoys significant relief of symptoms.

In order for skeletal balance to be stable it is essential to make certain that the arches of both feet are supported and that pronation/ supination of the feet is corrected. If this is not achieved by stabilizing the pelvis, another practitioner, the Podiatrist, may be required to assess the feet and prescribe the correct orthotics to support the arches. Neutral rear foot and fore foot position supports the pelvis, which in turn supports the cranium.

As a result of their cranial/dental distortions and the stress placed upon them during treatment, many patients become exhausted and run down. Due to pain and discomfort, a sometimes harmful diet and low energy levels, they often have high medication levels. To allow the body to re-establish some stability, especially in the early stages, nutritional support is imperative. Enzymes, minerals and vitamins, essential amino acids and fats are vital to allow the body's physiology to facilitate the structural changes. Ultimately it is hoped that this will free the patient from analgesics and anti-inflammatory drugs.

There is an unsettling trend of increasing numbers of patients who present with unusual and apparently unrelated symptoms that conventional medical tests, despite the sophistication of advanced technology, are unable to clarify. The long term effect is structural exhaustion, lowered immune system, pathophysiology and a breakdown in homeostasis. These patients and their problems cannot be fully resolved with conventional medical or dental therapy which doesn't acknowledge that any injury to the body is an injury to the nervous system. A sound understanding of the effects of structural instabilities on the nervous system and their compound symptomatic profiles is needed.

It is thus left to the new age of multidiscipline, holistic treatment teams to address all the issues and provide a rational and functional protocol. These teams by necessity will have knowledge of dynamic structural change and through perseverance, in spite of criticism, will influence orthodox thought to achieve benefits to all of our patients in the Twenty-first century. I feel privileged to be a practitioner in just one of these new age treatment teams.

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