THE AUSTRALASIAN SACRO OCCIPITAL TECHNIQUE BULLETIN.
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COMMENT My editorial last month certainly stirred a few. Good. We have received much favourable comment which is very heartening and one or two felt it was a little blunt and to the point. However one took the trouble to call me personally and roundly condemmed me for the article pointing out that each individual should practice chiropractic as he or she sees fit as this is a matter for personal outlook. He claimed a number of people had called him to complain and that he did not subscribe to the newsletter to hear our point of veiw. This is surely the perogative of any who subsribe to any form of journalism be it large or small. But it is laughable that the threat of the withdrawal of a subscription should be used as blackmail to change editorial policy to conform with this particular chiropractors point of veiw.
Any editor of any publication sets the tone for that publication as indeed it is his right. Our point of veiw is well known and the editorial simply emphasised this.
I have written to this chiropractor inviting him to express himself in answer to the editorial and will be happy to print the reply. To date nothing has been received. Perhaps next month I will reprint my letter to him and his reply. Further to this if any would like to write to us whether it be in the form of an article or a letter expressing a point of veiw or educational information then it will receive favourable consideration.

POST MELBOURNE A wonderful seminar attended 37 wonderful chiropractors. Yes some faces were missing for a number of personal reasons but we know they will be with us at future seminars. This time we introduced a written paper for all to sit. This was a test of basic knowledge and should have been easy to the advanced group and with the refresher group not sitting the paper till the second day it should have been equally easy. The results were in some cases very disappointing and in others very gratifying. Of the advanced group some either did not take it vey seriously or have a very patchy knowledge of S.O.T at best. These papers will become a regular feature of our seminars and the results will reflect your overall competence in the art and just how much study you do. You come to our seminars to learn S.O.T. and it appears from some of the results that we have fallen down on the job of ensuring that you have indeed absorbed what we impart to you at each seminar. Some of you are not using all the work and come along just to pick and choose what may be useful to you in your practice on certain cases which may confront you from time to time. Others of you are endeavouring to use the work all the time and if you do not follow the proceedures as we teach them then your results will not be good. There is no good in trying to sandwich S.O.T. into your present proceedures for S.O.T. demands the correct approach to get satisfactory results. S.O.T. works brilliantly when used properly and is not fiddled in with other lesser techniques. Not saying other techniques don't work but that S.O.T. gives the finest basis for locating and removing subluxations within the nervous system.
We have decided not to publish the results of this first test but in future you can expect this. The marking was done by myself and I was most lenient. If Keith had done the marking then some of you could have expected a rather embarrising result indeed. For as Keith say's you are either right or wrong. If you want your paper send a stamped envelope.
1. With disc syndrome no transverse pain sciatica down left leg. Without disc syndrome right transvers pain of atlas and right sciatica. Spine not inclined laterally but anterior lean possible with associated psoas problem. An extremly severe L.B. pain without sciatica may also be possible as is numbing of the legs. (nobody answered this question correctly)
2.R plus C technique is the use of an indicator to control pain in the lumbar subluxation. You can control pain and relax muscles and often can make an adjustment thr ough the muscles. R. is resistance to disease and C. is the contraction, cause of disease. Those of you who explained the indicators and their relationship to the lumbars received credit as did those who went further and explained the technique.
3. Change the side of leg traction then retest if no better give a left $ correction then send the patient home. Those who went cranial after changing leg traction because there was no improvement would have received a bonus. (many answers received on this were woeful)
4. Lay the patient on his back propping him up with a dutchman roll and perform a Cat.3. psoas correction by moving the knee inward and forcing the psoas outward. Those who advocated a standing S.O.T.O received some credit.

5. Incorrect blocking, occupational problem, visceral reflex, cranial, arm problem, rib, clavicle, diet, occipital sideslip, C1.C2., or a lumbar problem e.g. 4L. (poor answers)
6. Orthopoedic blocking. Supine High block left side, Prone high block right side. The obvious is supine blocking. Some answered with R=C and manual adjustments. This in my opinion would be to severe as gentleness is required to get the patient mobile before using these other approaches.
7. Category 1. A-P motion with side sway less than ¼inch.
Category 2. Side sway in excess of ¼inch with sometimes a circular motion as well.
Category 3. No motion antalgic posture.
8. 1) Tension both heels with thumbs on the calcaneus the one that gives the least or tighter heel is the side of heel tension.
2) Hold both heels so that both of your thumbs are equal ask the patient to expire then cough at the end of expiration 3 times. The side opposite heel tension will grow longer.
3) Have your assistant traction one heel at a time. You feel each atlas transverse. The atlas will move laterally on the side opposite heel tension.
9. The patient is a category 1. Rib head motion is one key and heel tension is the other. Many of you were fooled by the sciatica and the antalgic posture. Heel tension is NOT found in a category 3. neither is rib head motion or rib head sensitivity.
The second part of the question is yes. Possibility of prostate cancer.
10. SB+ 5L bounces ceilingward. Spinal dura is in extension.
SB- 5L jerks headward. Spinal dura is in flexion.
SBN 5L bounces then jerks headward. Spinal dura is in normal flexion and extension.
Adjust SB+ on expiration. Adjust SB- on inspiration. (any who gave this last part -bonus)
This was not a difficult test in our opinion but did show up deficiencies. Those who really should have done better will no doubt do well next time and will know that these tests are given for your benefit and are to be taken seriously by all.

OMAHA This year 21 Australians took part, a record. All who attended considered it a great experience and many will attend next year with me. Many fascinating improvements were released and the results we have experienced in using this new work have to be seen to be believed. Those who attended for the first time had an awful lot to contend with and no doubt by next year will know exactly what they are looking for. The most disappointing aspect of the seminar was the poor attention received by many in the clinic. It would seem that many of the clinic doctors were simply not up to scratch which is indeed a pity. Keith was presented with a special award for outstanding service to S.O.T. and was one of 7 to receive an official S.O.T.O. teachers certificate.

EQUIPMENTThere has been a price rise. (what's new). Foot Roll $18. Complete Set $42.50 Child Blocks $16.50. Anterior Block $11.50. Individual pieces have risen accordingly. We have 6 sets of equipment,6 anterior blocks and 8 Child sets still at the old price so if you want them send in your order. Occipital spinal charts are also available.

TROCANTER BELTS.We took to Melbourne with us 90 or so belts. Needless to say the lot were snapped up. We have placed another large order and expect them next week. Providing there is no price change from the manufacturer they will be available for $4.50 each. They are very well made and are very good value as they are designed for the job and provide the proper support needed in handling the chronic and acute Category 2. patient once they leave your office. Just write outlining the number you need and we will send them with of course a bill.

QUESTION Last month the answer was. SB+ adjust on expiration. SB- adjust on inspiration.
Q. You have a patient who apparently is a Cat. 2. as there is a fossa failure. However on further testing you find the first rib is subluxated laterally causing a weakness of the arm giving a false fossa test. Describe the proceedure you would carry out to adjust.

CERTIFICATION PROGRAM We are considering an examination program in both written and practical form with a veiw to issuing certificates of proficiency at three different levels. Basic, Advanced and Master in the practice of S.O.T. Basic is just what it says. Advanced will cover up to and including CMRT in all aspects and Master will cover all phases up to and including cranial technique. This would naturally take some time to fulfill but it is an idea which in our veiw has merit and will we are sure raise standards.

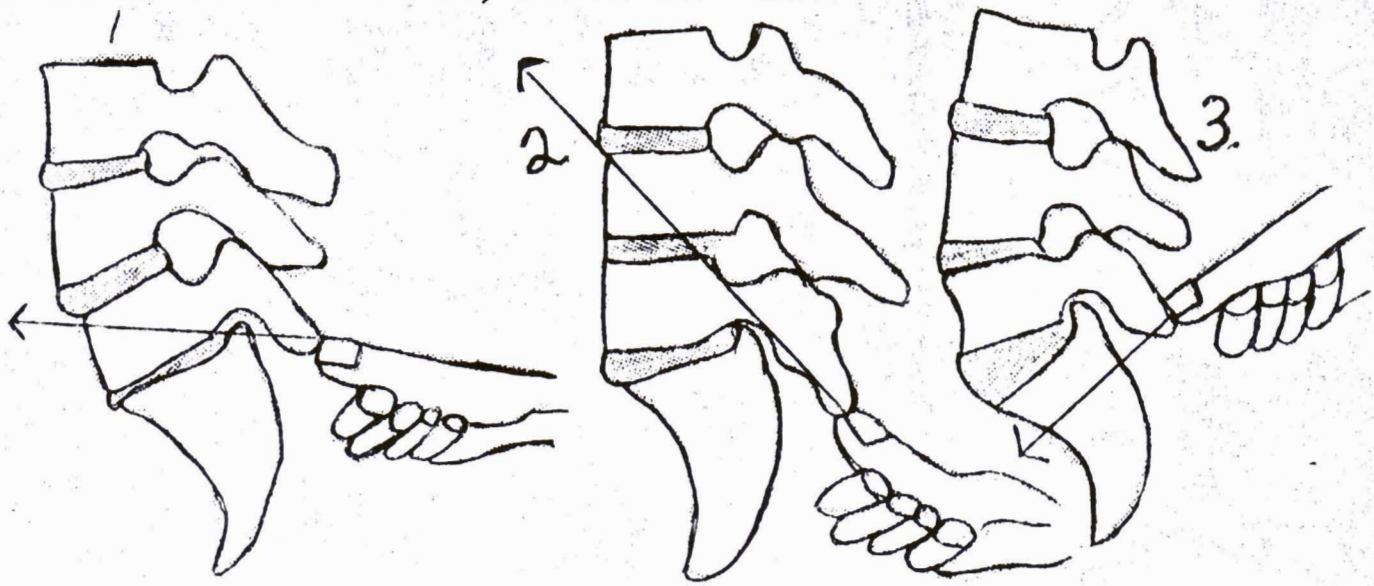
This is only an idea at present and subject to modification as ideas come to hand.

I.C.C. We will be sending a cheque to our College of $400 as a result of the Melbourne seminar. This represents $200 from each of us to the running expenses. We understand the College council is asking each member to contribute this amount each to help meet the the deficit. Please each one of you give willingly. If this College goes down the drain Chiropractic will receive the gravest setback ever in this country. Our future depends on us all. We know you will all help.

CATEGORY 3. DISC TECHNIQUE. On page 121 of the 1975 Notes lumbar disc technique is explained. This is a slight modification on previous notes. Below is the other method. We have used this with good results.

THUMB CONTACT FOR THREE DISC POSITIONS

IT IS IMPORTANT TO INSTRUCT YOUR PATIENT AS TO HIS BACK MOVEMENTS. HERE IS A PATIENT WHO IS VERY UNCOMFORTABLE SITTING AND OFTENTIMES IT IS IMPOSSIBLE FOR HIM TO SIT FOR VERY LONG WITHOUT AGGRAVATED HIP, BACK AND LEG PAINS.



MOVEMENT NO. 1. YOUR THUMB CONTACTS THE SPINOUS TIP OF LUMBAR FIVE. PRESSURE IS STRAIGHT THROUGH PATIENT. PATIENT MUST KEEP HIS HEAD DOWN TO CHEST. THIS CREATES BACK AND LEG PAIN, BUT HAS TO BE ACCOMPLISHED. KEEP HEAD DOWN. NOW PUSH WITH HANDS ONTO KNEES SO LUMBAR SPINE WILL BE MOVED POSTERIORLY. DON'T MOVE BUTTOCK, MOVE LUMBAR SPINE AGAINST YOUR THUMB CONTACT. THIS TAKES FIVE SECONDS.

MOVEMENT NO. 2. ANGLE YOUR THUMB UPWARD AS SHOWN. PATIENT NOW STRAIGHTENS SPINE, BUT KEEPS HEAD ONTO CHEST...IMPORTANT...KEEPS HEAD ONTO CHEST...MUST NOT LOOK UP. AS SPINE IS STRAIGHTENED, PRESSURE OF VERTEBRA INCREASES AGAINST YOUR THUMB.

MOVEMENT NO. 3. ANGLE YOUR THUMB DOWNWARD. PATIENT MOVES LUMBAR SPINE FORWARD. THIS REVERSES THE MOVEMENT OF #1. FOLLOW THROUGH WITH YOUR THUMB PRESSURE.

REPEAT.

THE THREE MOVEMENTS, ONCE THE PATIENT UNDERSTANDS WHAT HE IS TO DO, REQUIRE ONLY FIFTEEN SECONDS. REST FOR FIFTEEN SECONDS, AND REPEAT THE THREE MOVEMENTS AS YOU DID THEM THE FIRST TIME.

REPEAT AGAIN.

LEG PAIN SHOULD NOW EASE IF THIS IS TO BE EFFECTIVE...WITHIN THIRTY SECONDS, YOU HAVE PRODUCED A MIRACLE IF IT IS POSSIBLE...STOP NOW.

SUBSEQUENT VISITS.

DISC TECHNIQUE SHOULD NOT BE REPEATED ONCE IT IS EFFECTIVE IN RELIEVING THE SCIATICA.

WRITTEN EXAMINATION GIVEN AT THE RECENT MELBOURNE S.O.T. SEMINAR.

(answers commence on page 1. of the newsletter)

1. In a category III on X-ray, 5th Lumbar spinous is rotated right. What may be your physical findings?

2. Define R + C Techniques?

3. You have a right sphenoidal. The Right Dollar sign dramatically worsened after 2 applications of the Sphenoidal Technique. What would you do?

4. You have a Category III patient. He is bent forward so much so you cannot place him face downwards on the table. What would you do?

5. A Category II RUMS keeps recurring. Outline as many things as you can think of that may be wrong?

6. What adjustment would be advised in the case of a bedridden patient with a right spinous rotation of Lumbar 5? Describe?

7. Describe the signs elicited from Plumbline Analysis and their relationship to categories?

8. Give specific directions for Heel Tension testing for listing of a Category I patient? All 3 types of testing must be explained.

9. A male patient presents himself to you. His spine is inclined to the right and sciatica is present in the right leg. He does have some bilateral rib head motion and sensitivity and while the right leg is short on prone measurement heel tension is marked on the left.

   (A) Would you handle this patient as a Category III? Why?

   (B) Has right leg sciatica any significance in the male? Why?

10. Describe SB+ and SB- and SBN relating Dural Tension to each test?
