THE AUSTRALASIAN SACRO OCCIPITAL TECHNIQUE BULLETIN.
Keith C. Bastian D.C. | Published by | P.O. Box 238,
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MELBOURNE. We are looking forward to the most challenging Seminar yet for us. Never before have we tackled teaching cranial work and never before have we been involved in the instruction of people who have no chiropractic educational background in the normal sense. The Assistants program will be extremely important for without proper Assistant headholds Cranial adjustments may as well not be attempted. We are inviting all assistants and or wives to attend for the Friday only. The course will be as complete as is possible in the time available and we expect each assistant to be of immediate help in your office on her return. The cost of registration is minimal so send along 2 or 3 but only those Doctors who are eligible to attend the Friday session may send Assistants along.
At this Seminar on the Saturday and the Sunday I will present new work in relation to Category 2 which will enable you to do a better job. It would appear also that many of you are not doing to well in the basics so a quick review will be carried out before going onto the advanced work. There will also be an examination this time at the end because the results last time were really quite embarrassing to us all. All who attend can expect to participate and work hard to help make this the most exciting seminar ever.

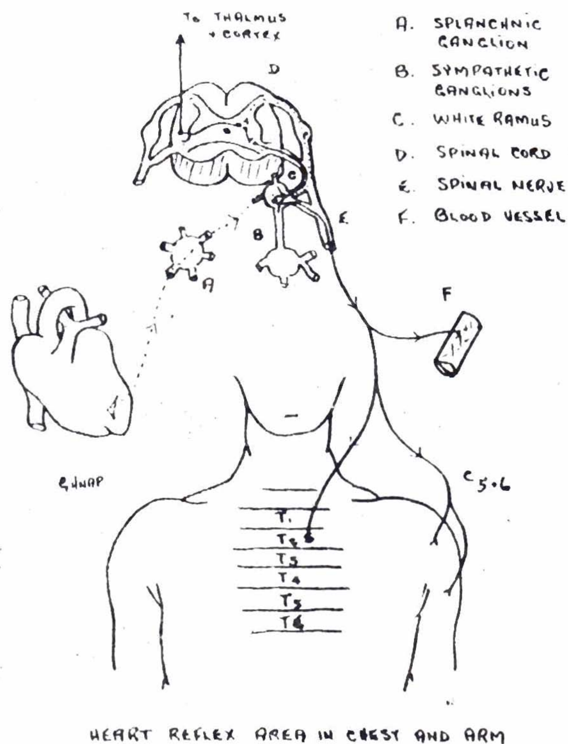
I.C.C. Shortly another year will start and a much more sober attitude must prevail. Gone are the heady days of the commencement of 1975 when we were all in dreamland. However by dedication and determination and a few digging deep the I.C.C. has survived a nd is ready to face a new year in a new location and hopefully more stability will prevail. 29 hopeful students started in 1975. Now we have probably about 16 or 17 prepared to start into the second year. Of the 29 this is approxamately what has happenned. 5 have dropped out. 4 have failed. 4 have conditional passes and 16 have passed. Of the 20 who have passes 1 my son-in-law is returning to the USA to study at Palmer full time and will graduate in three years time not the four and a half years extra he would have to face if he stayed at the I.C.C. Probably three won't commence this year because of financial reasons thus probably only 16 will start this year. In consideration of the expenses involved in running this institution then these 20 students are a luxury indeed, however on returning to the USA recently and speaking with educators there it is fast becoming a reality that the education of foreign students in Chiropractic will become a thing of the past. We have no choice but to support the I.C.C. to our last breath or else send students off to the psuedo schools here in Australia. Already one of our more advanced technique teachers has been approached to teach in one of these schools. They are without doubt sincere in their endeavours to upgrade and are willing to pour in the money to do it. This brings me to the point that up to the present the I.C.C. has not had the full support of everyone in the profession and if it were not for the efforts of a few then I.C.C. may have gone to the wall,it appears on the surface at least that the psuedos care about chiropractic more than we. There is no use saying to yourself and others complacently that they don't have the education etc. we have all said these things. The facts are that many of these individuals do a superb job in restoring the sick of the world. To long we have sat back and expected politicians to see how brilliant we are, well finally we have begun to realise that things don't happen that way, hence we have become more active politically and now we have our own educational institution amd if we don't get behind it fully then it won't be hard for me to envision our better technique instructors guiding the psuedos towards greater competency. The choice is yours.

FUTURE SEMINARS At present no future seminars have been planned as wehave had to assess the I.C.C. program (extension) but as yet no firm decision has been made on that. I have a tentitive invitation to present a full beginners Seminar in NZ. in May when I will be there for 2 weeks. I t is a little late to organise one now for March so April looks ideal to have a beautiful Seminar in the Jacaranda City of Grafton. On the last page will be a form to fill in to indicate who you know would be interested in Grafton as a venue to take the beginners course and naturally you will reply in the affirmative.

QUESTION Last month- The patient has a disc involvement as all signs stated indicate this
Q. What three major signs indicate a Category One patient. ?

of the segment from which the organ was originally derived.

These areas are, of course, subject to dermatomal overlap resulting in adjacent areas being sensitive to pain. As shown in diagram No. 1, the pathway of visceral pain afferents form what we call the Viscero-Cutaneous Reflex. These can be used for diagnostic purposes, as well as, therapeutic (in which case the reflex becomes a Cutaneo-Visceral one reversing the pathway and stimulating the organ of origin).



HEART REFLEX AREA IN CHEST AND ARM

DIAGRAM # 3

The anatomical distribution of the reflex points (diagram No. 2) are located at the bifurcation of the three main motor nerves of each spinal nerve from thoracic 1 down through lumbars 1-2-3 and sacrals 2-3-4. The first group, junction of the lateral and medial branches of the Posterior Primary Ramus, supply the paravertebral regions. The second group, at the bifurcation of the lateral branch of the Anterior Primary Ramus, supply the anterior lateral regions of the body. And the third group, at the bifurcation of the anterior branch of the Anterior Primary Ramus, supply the anterior medial portion of the body. In a case of hepatic disturbance the cutaneous reflex points appear in a localized area within the right half of thoracics 6-8 dermatomes. It should be noted that the hyperalgesic zones appear on the right side. It is characteristic that the visceral reflex will be found in definite areas of the right side dermatomes. This would apply to each visceral reflex, while the visceral disease is projected to the skin as a viscero-cutaneous reflex. The stimulus on the skin is projected into the organ as a cutaneo-visceral reflex. The former gives a base for diagnosis and the latter for therapy. The transmission of pain is mainly through the lateral spinothalmic tract and most of these fibers terminate in the hind brain except for a portion which passes up to the thalmus. They excite the reticular formation which transmits signals upwards to the thalmus and hypothalmus and increases the excitability of the brain (the central grey pathways are also involved). There is, however, a tegmental pathway which suppresses pain sensations. Upon receipt of the signal, the brain (by a complex and effective reflex from the motor cortex) stimulates the tegmentum to lessen the pain reflex. When there is an extra stimulation at the root level, this system is activated to alleviate the eschemia by the mass reflex system (chapter 53, Guyton).

All the viscera are dependent upon a dual and complementary nerve supply, namely, the sympathetic and the parasympathetic which to an extent is governed by the higher centers in the central nervous system; the regulatory centers in the medulla, the thalmus, the hypothalmus and the cortex. The sympathetic and parasympathetic have both pre- and post-ganglionic synapses. The sympathetic has a greater amount of post-ganglionics and is more alerted by a mediator fluid called epinephrine (adramine) which is secreted at its synapses. The parasympathetic is more under the influence of acetylcholine; consequently, they are known as the adrenergic and cholinergic systems, respectively. At the synapse the nerve endings have the ability to secrete both acetylcholine and epinephrine. A post-ganglionic block would mean a loss of epinephrine at the synapse and a preganglionic one would mean a loss of acetylcholine (an excess of acetylcholine can institute a sympathetic discharge — Guyton, pages 822 and 823).

The norepinephrine and epinephrine are secreted into the blood stream by the adrenal medulla and are not removed or destroyed until they diffuse into tissues; therefore, when secreted into the blood they remain active. There is an inhibitory transmitter, the exact chemical nature of which is unknown, but is thought to be gamma aminobutyric acid (GABA) and is believed to inhibit the excitatory action of the presynaptic terminals. Thus, GABA acts as a regulator to prevent over excitability of the central nervous system and is dependent upon the presence of vitamins B, especially B6, which is secreted by the liver into the blood stream under excessive

neural fauculation. Without a good threshold of B6 the central nervous system can be thrown into an autonomic storm resembling epilepsy. Reflex stimulation over the mid-sternal area appears to increase the ability of the nerve endings to secrete acetylcholine which, in turn, affects the motor reflex action resulting in an increase in the action of the moderator fluid — GABA. On the other hand, a post-ganglionic control over the area of the carotid plexus produces an increase in the formation of epinephrine.

In conclusion, by stimulating the reflex areas through the neural pathways and reflex dermatomal areas, we can bring about a reversal of pathology by increasing nerve root level stimulation and blood supply. Generally, a light contact acts as a stimulant and a heavy one as a depressant. Reflex work in the area of the colon will usually increase its peristaltic action which, in turn, results in an increase in the lymph circulation of the abdomine. Thus, Chiropractic Manipulative Reflex Therapy helps to restore normal nerve, blood and lymph supply to the viscera!

EDITOR'S NOTE—

1. CMRT becomes the procedure of choice the moment visceral malfunction begins and through diligent analysis (occipital line 2 procedure) we can be forewarned of possible impending pathology at its inception (no medical tests exist, to-day, that can claim as much).
2. CMRT carefully applied cannot only reverse anomalies at the functional level, but, also, at the pathological stage.
3. No, CMRT is not a panacea, but even when pathology has progressed to a point of no return, it can relieve and prolonge.

Dr. Dangerfield is to be complimented on this very fine article for it goes a long way towards explaining the why's and how's. Unfortunately, this resume is not the whole of it, but covers quite well what is known about it, to date.

Fortunately, the efficacy of CMRT is not in proportion to our ability to explain it — IT WORKS WONDERS. A very good point in case is the age old Chinese art of acupuncture which through the years, and especially recently, has been sophisticated to such an extent that, today, Chinese physicians use it, for precise, predictable local anesthesia. Yet, none of those using it have, to date, been able to come forth with an acceptable scientific explanation as to why. The only undeniable comment, so far, is "It works".

FINIS.

QUOTES FROM THE PAST.

80% of man's function lies in the cranium. Outside the cranium you have locomotion and feeling.

All problem children have cranial problems. Cranial technique could make most retarded children trainable and self sufficient.

Thirty seconds of cranial work would do more good than months of rehabilitation.

Talk to the brain so that it knows what you want it to do. Tell it you have removed the cause of it's trouble and that now function can be restored.

If the leg goes dead, the brain isn't working. You adjust and start the generator, but then you have to tell the brain what it should tell the leg to do.

People don't get results with cranial technique because they don't tell the brain what to do after the correction.

We give a specific adjustment with a specific result expected.

Do not use S.O.T.O. in the supine.

Cat. 3: if disc herniated the S.O.T.O. will cause a hot pain to shoot up the leg and hip: surgery immediately.

With children: put finger on the hard palate and see that normal motion is made in all directions.

You must have a price scale for what you do...Not so much an office call regardless.

Surgeon cuts: Radiologist burns. Cobalt may prolong life but developes uncontrollable radiculitis. If it does let the patient live longer he suffers more.

Persons who survive surgery or cobalt did not have virilent cancer though it may be malignant in lab tests.

Malignancy starts in the brain with personality changes. People begin to hate what they loved before, be it food, work or people.

Cancer signs: (early) aversion to fingers in cold water, or tingle in hot water.

Drooping eyelids:- tumor of apices of the lung,

Persistant female left sciatica suspect uterine malignancy.

Prostatic malignany shows increase in bone density.

Multiple sclerosis must have poly-unsaturates. Soy bean oil - natural estrogen.

The thing that stops the flow of nerve energy is in the torsion of the dural sleeve on the nerve. This stops circulation to the nerve.