THE AUSTRALASIAN SACRO OCCIPITAL TECHNIQUE BULLETIN.
Keith C. Bastian D.C. Published by P.O. Box 238,
Scott D. Parker D.C. March 1976 Grafton NSW. 2460.

THE FUTURE General standards need improving. We feel as though to some extent we could do better in our Seminars both in the practical and teaching aspects of S.O.T. However we also feel that each one of you can do MUCH better than at present. Very few of you go home from each Seminar and genuinely study and many of you are not putting enough S.O.T. into your everyday practice because you lack the confidence in the approach.

We have decided as a result of the two examination papers issued at recent Seminars and also an open invitation to criticism and improvements in our Seminar presentations to make the following alterations in the teaching program for S.O.T. to the field in Australia.

1. Seminars will be conducted in a series.
2. The series will be on a one Seminar per month basis alternating between 2 or 3 main locations in Australia.
3. A voluntary certification program will be run in conjunction with the series and attendance at each Seminar is required in order to be eligible for certification. If certification is not required attendance at all Seminars is extremely advisable so that nothing is missed.
4. Those who consider themselves adequate for the first three stages of Certification will be invited to submit an application for subsequent approval and testing. (those passing will be invited to assist at all of the series up to the level they have attained.)
5. Those who have passed Stages one thru three of the Certification program will be eligible to move onto the advanced program and so on.
6. Those who do not wish to take part in an examination program but who want to attend and to go on to C.M.R.T. will be checked on their knowledge of practical application only. Whilst this is voluntary no one will advance until practical knowledge of the basics is checked.
7. Dialogue has been established with Dr. Kleynhans re the inclusion of this Certification program into the I.C.C. Advanced Education Division. Naturally this will augment the finances of the I.C.C. if this is acceptable to all.
8. This program is designed to upgrade the standards of the S.O.T. practioner in the field and to upgrade Chiropractic in Australasia. We hope all who participate will take a pride in this program for other than Dr DeJarnette's S.O.T.O. qualification there is no other study course with a similar certification as to standards reached in S.O.T. anywhere.
9. This is a projected course of action and requires further approval however the basic ideas will remain. We would welcome any thoughts or ideas from anyone. Just write care of the above address.
10. We anticipate commencing in May or early June in order that we complete studies before Christmas.

The 6 weekends will be taken up as follows:-

1. Category 1. --- Two months.
2. Category 2. --- One month.
3. Category 3. --- One month.
4. Reveiw --- One month.
5. Reveiw and Occ. Fibre work. One month.

This totals 6 months. In conjunction an advanced class will be run and those who are so qualified may participate. Out patients who are seen at the seminars will be adjusted by members of the advanced group, except in the last 2 months.

PATIENTS AT SEMINARS Most of you who have brought along patients to be checked at our Seminars have been neglecting to inform your patients of one or two things, so they do not know what is in store for them. All patients seen are expected to donate the sum of $10.00 to the I.C.C. often when prompted the poor patient knows nothing of his obligation. Also many patients are extremely nervous when so many Doctors are looking at them in our Seminar room. Inform the patient that this will occur and also that the students at the Seminar will be working on them as this is a teaching clinic, however everything will be properly supervised. If a patient requires an individual consultation

then special arrangements will have to be made and the consultation will be $25.00.

THE CERTIFICATION PROGRAM

STAGE 1.	....	Category 1.
STAGE 2.	....	Category 2. History of Dr DeJarnette and S.O.T.
STAGE 3.	....	Category 3.
STAGE 4.	....	Fibre idendification Line 1.2.&3. and their associated segmental levels. Trapezeus and segmental levels. Basic S.O.T. Nutrition(DeJarnette - Denton, Bonte.)
STAGE 5.	....	C.M.R.T. D1. - L5. Line 1 adjusting proceedures. Line 3. proceedures.
STAGE 6.	....	Philosophy Science & Art. Known Physiology and Neurology. Extremities. First Aid.
STAGE 7.	....	Cranial Anatomy, Physiology and the Cerebro spinal fluid system. Basic holds and their function.
STAGE 8.	....	Total field of S.O.T. Categories, C.M.R.T., Physiology etc. Total Cranial. Examination to be conducted by Dr DeJarnette after a minimum of 2 Omaha Seminars have been attended.

CATEGORY 2. AND ITS ASSOCIATION TO HYPOGLYCEMIA.

The following is a paper presented to a select S.O.T. review Committee at the 1974 Omaha Seminar to gain approval for presentation in 1975 in the advanced section of the S.O.R.S.I. Omaha convention. I have been given approval to print this paper by the author DR. C. CURTIS BUDDINGH D.C. of Chalotte Michigan.

When I first began applying S.O.T. five years ago, it held many frustrations and questions as to why some patients were not responding as anticipated. Dr. DeJarnette's proceedures, naturally, were correct, but my error was in the proper recognition of a Category 1. and a Category 2. The following are my observations, made and noted over the past three years. These consist of the fine line of difference between a Category 1. and a Category 2.

In a Category 1. P.S.S. correction, it was noted repeatedly that the dollar sign area had a slightly increased muscle tonicity on one side in comparison to the other side. This dollar sign would, in many cases occur opposite to the crest sign. For example, a right dollar sign with a left crest sign. Most of these patients illustrated a bilateral rib head pain without lateral sidesway.

Upon checking these patients again I noted that additional unilateral muscle distortion was present with paired muscles. For example, the anterior abdominal muscles would increase in strength on the right to compensate for the left crest. Noting the asymmetry of the dollar signs and the crest sign, supine evaluation of the pelvis was made and the following noted : The Category 2. indicators were present, with pain in the area of the upper fossa, medial knee pain on one side, pain in the lower fossa and lateral knee pain. These patients were treated as a Category 2., and after the pelvic correction the muscular system showed a single finding of a dollar or crest sign.

Other prone indicators on various patients that did not have the unilateral dollar and crest sign were : These patients would stand stable in thr distortion analyzer. Palpation of the sacral lateral ridge would be painful with a swollen nodual mass along the insertion of the sacroiliac ligaments. The pain would also be noted at the lateral margin of the P.S.S. right and/or left. If pain was found on the lateral margins of both P.S.S., a UMS and LLL indicator would be found upon supine evaluation. If the pain on the P.S.S. was unilateral a unilateral Category 2. indicator would be found.

Using the Category 2. proceedure, termed as an under-lying Category 2., the pelvis would be stabilized and clinical symptoms would usually be eliminated by the fourth office call. Upon rechecking the lateral margins of the P.S.S., which previously were painful, joint edema was still evident even after equal leg length was established. The intensity of

the pain would be less at the P.S.S. and could be completely removed by using the occipital fibre line 2., area four neutralisation proceedure, similar to that for a vertebral process. Using the occipital fibre line 2., area four for sacroiliac rehabilitation, other reflexes began to be revealed. Upon noting the second sacral forarinal pain, the neutralization which takes place with the use of the occipital fibres line 2., area four and line 2., area six would neutralize the pain at fourth sacral area as this region would also be involved in the separation of the weight-bearing area of the sacral boot.

Occipital palpation was used as a routine part of the proceedure for all new and regular patients to correlate the findings of the occipital nodule on line 2., areas four and six with the findings of the sacral nodules. All the patients were checked in a supine position with palpation of the Poupart's ligaments along with the occipital fibre analysis. I noted that the patients that had the formation of the nodule on line 2., areas four and six would fall into Category 2. classification.

To emphasize an important point - The occipital nodules on line2., areas four and six are involved on both sides of the occiput. If all four fibres are not present in an abnormal state, the patients condition will become worse with the use of Category 2. proceedure. (There is one exception to this finding, which will be explained later.)

In reviewing the occipital fibre chart, notice that the occipital line 2. area four is also associated to the sixth dorsal and second lumbar, and that occipital line 2. area six is also associated to the eighth dorsal and fourth lumbar. Since a Category 2. is associated with both structural fault and neuromuscular problem, the nodular trapezuis should be involved too. The trapezuis is associated with the occipital line 1. chart. Area four of the line 1. includes the sixth dorsal and the fourth cervical and you should find an involvement with either one or both of these.

Using the trapezuis Tong test developed by Dr. David Denton revealed that nearly all Category 2. patients had a neuromuscular reaction along the lamina pedicle junction of cervical four on the left. This finding was rewarding since now you could test the left mastoid in the distortion analyzer and check the fourth cervical with the occipital fibres in the standing position to determine what category the patient was. This made things alot simpler in my own classifications.

The nodulation on fourth cervical played another role besides the pre-determination of a Category 2. When the patients leg length became equal in the blocking proceedure and the trochanter belt was applied, after the patient walked for approximately five minutes the nodulation on fourth cervical would diminish. In re-checking the trapezuis by the Tong test I noted the nodulation of the trapezuis four had diminished. The diminishing of these neuromuscular indicators revealed that the upper torso had re-adapted to the normal postural attitude.

If you recall from the C.M.R.T. Notes, a nodular formation on the occiput would indicate visceral pathology or malfunction. I have explained that Category 2. patients have a nodular formation on areas four and six. If this information is to hold true you should find a pancreatic or a liver reflex or a colon and/or a cecal reflex, depending on the level of cord involvement. In checking for the nodulation at the transverse process of dorsal six and lumbar two, I found that the majority had this reflex at the level of dorsal six. The nodulation on dorsal six would be bilateral with associated right thenar pad pain.

In working with my latest observation, the thenar pad pain, I noticed in the Category 2. patients that as they were being blocked the pain in the thenar pad would start to diminish as the leg length returned to normal. This was an interesting discovery for me because now I could check the thenar on the right and if there was pain put them in the supine position, block them as determined by the short leg and let them lie there until the pain had left the thenar. I would then belt the pelvis and have them walk until the neuromuscular nodule on the left of cervical four would leave. I started to treat all Category 2. patients in this manner. If there was no thenar pain the legs should be equal and the cervical four nodual should be gone. This procedure has worked well without any complications.

At approximately the same time of my own research, Dr. DeJarnette introduced the arm fossa test for determining Category 2. patients. In using the arm fossa test everything correlated with the other indicators and reflexes that were present. However I found one instance on a Category 2. that the test would not be valid. The exception is as follows For the arm fossa test to be a positive indicator a short leg must be present. If the short leg is not present you do not have the tension on the Pouparts Ligaments and if this tension does not exist the arm will not weaken. However these patients can still be a Category 2. The pelvis can be separated at the weight bearing region without rotation to a posterior-superior position. If it is a weight bearing separation, the thenar pad pain is still present in all these conditions.

In revealing this pelvic position, I developed the neutral Category 2. block position. With the patient in the supine position, the blocks are placed directly opposite each other under the P.S.S. This position is maintained until the pain on the right thenar pad diminishes. The thenar pad pain on the right hand is an indicator, along with the pancreas, that the weight bearing portion of the sacroiliac articulation has been separated. In conjunction with the thenar pain on the right hand, you must also have the occipital fibre Line 2. areas four and six on both sides. If you don't have the occipital fibres in all four areas you don't have a Category 2. The reason this is brought out is important due to the different conditions that are encountered. One condition to watch out for is a traumatized lumbarisation or sacralisation, as this condition will produce the occipital fibre change on both sides but will not produce the right thenar pad pain. If you treat this patient as a Category 2. you are asking for trouble. Another condition to be aware of is a spondylolisthesis of lumbar four and five. This will also produce occipital changes without the pancreas thenar reflex. Also, the two previous conditions will, produce a positive arm fossa test.

To be continued.

WRITTEN EXAM MELBOURNE. Some of the answers given in this most recent test have given us both genuine cause for dismay. Particularly those in the advanced group who marked each others papers gave some very inadequate answers and received a full ten marks from their colleagues. I have taken the time to reassess these papers and many of you are in for a rude shock. Either you record a full answer or you only get credit for what you write. Here are two of the questions with answers from one of the class.

1. The patient has sciatica. How can you tell whether a lumbar disc problem or a subluxation caused it. (Answer. L. Bardsley D.C. Marks - 9.)

It would be a disc problem if the sciatica was on the same side as the postural incline. Patient in Category 3 antalgic position. On SOTO technique the pain would not increase but would continue to pain. The leg could be brought out to SOTO position without further aggravation of pain. There would be no cervical indicator pain.

(These points were missed. 5L-4L spinous rotation away from sciatic side. Leg has no tension on SOTO and withering of the leg muscles usually indicates disc problems)

I have left one point till last. How many of you picked it out? Pain into a calf muscle and/or the popliteal area. (Lydia hai this point correct)

5. Define and explain R + C technique. (Answer N. Creed D.C. Marks - 10.)

R + C is a pain control technic. R = Resistance or indicator to disease
C = Contraction or location of lesion.

Lumbar subluxations have a corresponding cervical indicator or "R" factor.

	L.5.	Rotation	Pain on posterior arch atlas
	L.4.	Rotation	Pain on lamina axis.
"R" Indicators	L.3.	Rotation	Pain on transverse of 3.C.
all on same	L.2.	Rotation	Pain on transverse of 4.C.
side,	L.1.	Rotation	Pain on transverse of 5.C.
	L.5.	Inferiority	Pain on styloid-mastoid.
	L.4.	Inferiority	Pain on axis spinous
	L.3. - L.2. - L.1.		Pain on spinouses of corresponding cervical indicates inferiority of lumbar on that side.

Proceedure to correct as follows.

Lumbar Inferiorities 1. Hold thumb on superior lumbar transverse while stimulating "R" until moist.
2. Hold "R" while elevating inferior transverse of "C" with a pumping action.

Lumbar rotations 1. Hold thumb on lumbar transverse on opposite side to "R" which is to be stimulated till warm and moist.
2. Stimulate lumbar spinous on same side as "R" while holding "R".

(This is the sort of answer we expect in the written part of the certification program naturally in the practical,demonstration and a complete explanation will be required.)

SEMINAR. Before the certification series starts in May/June there will be one more review seminar held in Australia. This Seminar will be taught from the 1976 Notes and there are a number of modifications to incorporate. For those who wish to go for the examination before the Series starts in May/June then this is a must for everything that will be expected of you will be covered up to stage 3. The series that will start in May/June will be a complete Introductory and follow thru Category 1.2.&3.
Also negotiations and arrangements are in progress to hold a three day Seminar in NZ. in May on 14th. 15th. and 16th. But as yet no details are available but an announcement will be made in the April Bulletin concerning this. For those wanting an overseas trip with a legitamate Seminar to attend then this would be good and will further prepare those for Stages 1.2.&3. and to start equiping themselves to teach S.O.T. with us in the future. For those going to Omaha this year we are devising a special inclusion at the August Seminar of the Series and we will entitle this " A cranial orientation." so that you may be able to absorb more readily what will be taught you at Omaha. This will not be a teaching Seminar for we are not authorised to do that but will prepare you to sort out what you need when you attend this fascinating Seminar.

S.O.T. TAPES I have had a number of requests lately to commence Tape 4 of the series " The Practice of Sacro Occipital Technique." Yes I will get around to it one day folk. Obviously an update is required to bring us into line with 1976 Notes on the first half and a continuation on the other. What I really need is time. Will do my best for you all.

S.O.T. SEMINAR CANBERRA

DATES: APRIL 3rd, & 4th.
VENUE: PARK ROYAL HOTEL, NORTHBOURNE AVE. BRADDON CANBERRA.

NAME: ______________________ STREET OR BOX NO. ______________

CITY: ________________ STATE: __________ POST CODE: __________

TEXT: THE 1976 S.O.T. NOTES ARE MANDATORY. (Don't send us $60. the week before the seminar and hope to get the Notes in time. If you haven't ordered them do it now)

EXTRA ORDERS: EXTRA ORDERS WILL BE SUPPLIED IF YOU ORDER IN TIME. USE YOUR PRICE LIST.

COSTS: REGISTRATION FOR S.O.T. REVIEW UP TO STAGE 3. TWO DAYS $55.00

INFORMATION: ROOM TARIFF, SINGLE $26.00. DOUBLE $32.00. You are expected to do your own room reservations with the Hotel.
If more Chiropractors register than we have calculated on attending then there will be a refund of part of your registration fee or if you wish a donation of it to I.C.C.

ENCLOSE THIS FORM WITH YOUR CHEQUE FOR $55.00 MADE OUT TO S.O.T. SEMINAR AND RETURN IMMEDIATELY TO BOX 238, GRAFTON. N.S.W. 2460