SOTO AUSTRALASIA

AUTUMN 2008

EXPRESSION

CATEGORY SIX – THE ANTERIOR VERTEBRAL SUBLUXATION

If you are a surprised reader of the title above, then this means you haven't been following our series of "Expression" articles. To inform you and as a review for others, DeJarnette extended the three category system to eight categories in 1970, then decided to return to a three category system the following year. The five extra 1970 category listings were:

Category IV	Occipital Fibre Analysis
Category V	Trapezius Fibre Analysis
Category VI	Anterior Vertebral Subluxation
Category VII	The Oblique Sacrum
Category VIII	Occipito-Atlantal Syndrome

We have presented Occipital Fibre Analysis and Trapezius Fibre Analysis over the last three Expression issues with the hope of expanding these topics on what you receive at our yearly seminars and offer some historical background and further details of the work for those interested.

The article before the Category Four was Autumn 2007's "The Anterior Thoracic Technique and SOT" which covered the bulk of Category Six, so we will limit our discussion in this article to lumbar and cervical involvement save for defining the difference of the meaning of the term "anterior" when used in the various regions of the spine.

Anterior Cervical, thoracic and Lumbar

Thoracic Review:

In the Autumn 2007 Anterior Thoracic "Expression" article we sourced Dr. Bruce Fligg's "Anterior Thoracic Subluxation" which appeared in the Journal of the Canadian Chiropractic Association (December, 1986) for his definition of the term "anterior." Fligg stated: "The anterior thoracic, by the semantics of its name, has produced some misunderstanding in its clinical application. Historically, the name came from the following two factors (i) the vertebral subluxation felt anterior (spinous) and (ii) the adjustive thrust was applied anteriorly."

The Saucer effect of the anterior thoracic subluxations had been noted by many including the thoracic Surgeon of the 30's - 50's era, Francis Pottenger who attributed gastric, liver and pancreatic diseases to its presence.

Dr. Burl Pettibon[2] in the 1970's suggested that the anteriorities of the thoracic spine were in fact appar-encies rather than realities in that the spinous processes appeared "dished" or "saucered" due to the rotational and lateral flexion nature of the misalignments which have a global, rather than a segmental origin and which are kept "in check" by the rib heads.

So that's a brief summary of the thoracic. The term "anterior" used in the cervical and lumbar spine has a different meaning. Whereas "anterior thoracic" is determined by palpation (or Prill tests[3], but we haven't written a paper on this yet so many of you won't know what we're talking about), the listings of anterior lum-bar and cervical are postural listings determined by plumb line or X Ray examination and mean the whole region is anterior of the ideal or in the case of Spondylolisthesis, that one segment has moved forward.

Anterior Lumbar Spine

Just as there have been misconceptions and various ideas of how the thoracic spine subluxates anteriorly, the lumbar spine has had its share of theories and fallacies.

The very first idea we had to disabuse ourselves of was Ferguson's angle. This you recall from Spinography class is the angle made when an oblique line drawn through and parallel to the sacral base is intersected with the horizontal line. Also known as the sacral base angle or the lumbo sacral angle, Ferguson "swore blind" that this angle should be 34°. Any increase led to an increased lordosis and a decrease would

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INSIDE THIS ISSUE:

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PRESIDENT'S REPORT – DR BRETT HOULDEN

Hi all, and welcome to the April Newsletter.

As I was chatting to some 5th year students today, it started me thinking of SOT and where it fits into the Chiropractic world. I felt so blessed to know what I know now, and Oh, how I wish I knew some of this stuff back then!

To know what to adjust, when to adjust it and an extra way other than traditional methods of how to adjust is simply something I take for granted now. Not back then, I really struggled with having some many ways to adjust every segment, I had lots of trouble sorting out in my mind when I should NOT adjust something. The look on faces as this concept dawned on some students new to SOT was something that was great to see, and wonderful to be able to share with the group. If all I did was to open one pair of eyes to the possibility that such an approach is not only possible, but is such a pleasurable way to practice Chiropractic, my day was very well spent. I do love going down to share some of the enthusiasm I have for Chiropractic, and especially for SOT. I now continually thank DeJarnette (even though I never met him) and his contemporaries for developing this marvelous technique. But then, I guess if you are reading this, I'm "preaching to the choir". I love getting out there and chatting with people who do not know much about SOT, and sharing how fantastic I find SOT works for me in practice.

Keep enjoying what you do, and spread the word to anyone who will listen, strive to have more of your patients go on to becoming Chiropractors themselves, then you know you are on the right track.

Yours in SOT, **Brett Houlden**

OUR CURRENT SOTOA LOCUMS

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WELCOME

to our New Members!

Steven Hawkins, Padstow, NSW
Samantha Haitsma, New Zealand & Locum
Tarryn Dawson, Sunshine Coast, Qld
Adam Purdey, Launceston, TAS
David Hodal, Toowoomba, Qld
Krystall Rawson, 4th Year, Macquarie
Marcus Kennedy, 5th Year, RMIT
Amber Laris, Adelaide, SA
Samantha Culley, Sunshine Coast, Qld

CALENDAR OF EVENTS: SEMINAR SERIES 2008

Session	Melbourne	Sydney	Perth	Gold Coast
Introduction, Categories I, II & III	April 11, 12 & 13	May 2, 3 & 4	June 20, 21 & 22	June 27, 28 & 29
CMRT	May 16 & 17	May 23 & 24	August 15, 16 & 17	August 29, 30 & 31
Cranial	July 11 & 12	July 18 & 19		
Advanced Module		July 19, 1.30 – 5.30pm		
Venue	***Rydges Melbourne*** 186 Exhibition St Melbourne 3004 (03) 9662 0511 1300 857 933	***Rydges North Sydney*** 54 McLaren St North Sydney 2060 (02) 9965 5105 1300 857 922	***Travelodge Perth*** 417 Hay Street Perth Res: 1300 886 886	***Gold Coast International*** 7 Staghorn Ave Surfers Paradise (07) 5564 1200 Toll Free: 1800 074 020

FROM THE EDITOR'S PEN

Dear SOT colleagues,

One of the main reasons I became an SOT practitioner was because as a student I was attracted to and inspired by the people I had met who used SOT. They seemed to be happy, content, wholistic, inspirational, beautiful people. These people embraced my passion for learning and mentored me for which I am truly thankful. In our office we regularly have chiropractic students working with us or observing. This hands on approach to SOT in the real world whether it be in technique or in practice management is something seminar series can't offer. We need to nurture this Doctor/Student relationship as it is an imperative factor in development of new SOT practitioners. I encourage all the Doctors to "give back" a little of their time and knowledge to help SOT grow in Australia and for those students out there interested in SOT to introduce yourself to a practitioner and get a taste of what life can be like when you embrace SOT.

Darren

LETTER TO THE EDITOR

Dear Darren

In recent editions we have had some background experiences of a few of the early stalwarts of S.O.T., which I trust has added a human face to those who have joined S.O.T. in latter years. More anecdotes could well follow from Bill McPherson, the brothers Creed, David Lovett, Mark Postles, Bill Logan, Graham Piera and others. Interesting as that may be for some of us, most people read the "Expression" for the technical understanding. My sincere commendations to our faithful editors over the years, to Averil, the Board, and in recent times the brothers Kyneur for the time, effort and research they have committed to you to help you be a better Doctor of Chiropractic.

The history of S.O.T. we each know and relate to, is coloured by what we have individually experienced and learnt. Those recently new to S.O.T. have necessarily a very limited view of S.O.T. The same limitations apply to those in positions of power in our political, banking and educational institutions to name a few obvious ones. Mistakes keep getting repeated by those who have not taken the time to study the past. A study of even the recent past by those supposedly in charge of our economic, or sociological endeavours would have avoided the almost totally incompetent handling of the current crises besetting the world: It was all totally expected by those who either had been around, had studied the history or even observed carefully, and applied some common sense. These latter people rarely get hurt by "new and unexpected developments". "Hey you! Yes you! Listen up!" The same is true in S.O.T. Everyone wants instant gratification, preferably with no commitment or effort or studying on their part, and anyway, of course they know everything before they start, don't they? I made a mistake when I was younger. Please all remember this. I am, yes Keith Bastian, admitting I made a mistake. Some will say that is the first ever admission. Not so. If you have a different opinion to me, it does not make you right, and me wrong. Show me the evidence and convince me it's reputable, and I have no problem in admitting I was wrong, if I am. That also applies to S.O.T., and to other techniques.

When I was 18 I was teaching in the Snowy Mountains, and we played a lot of sport – tennis, cricket, basketball, rugby league and hockey especially, all of which involved hundreds of **miles** travel per week. To have a dance or movie date on Saturday night would sometimes mean 150 miles on poor roads, in cars that did not even have heaters. Some of our parties involved going to Thredbo, Smiggins or Perisher or Snowy Mountains camps such as Island Bend. Enough said. On rare occasions we even had time to ski. The very first time I put on skils was at Thredbo. Jauntily got on the chairlift to have a look at the scenery and the snow bunnies, got off at the top and found myself with two choices. Get back on the chairlift and shamefacedly ride back to the bottom, or ski down the International Olympic run! Of course, I chose the latter. Eighteen years old, cocky, indestructible, fit, well co-ordinated, and of course good looking and humble. All that disappeared when I started down the 45-60° slope with over 1.5 kms to the bottom. Not only could I not ski, but had never been on skils, or been taught to snow-plough or herringbone even. I eventually got down in one piece, but how many did I jeopardise on the way?

Which brings me back to S.O.T. Right back from 1974 when Scott Parker and I began to teach S.O.T., people who had been to one seminar, barely knew what a block was, had a very basic and patchy knowledge of categories, all wanted to immediately learn the "advanced" work. Transpose this to a refugee from Afghanistan who may know what a soccer ball is, but with limited skills, not even knowing the language, arriving in Australia on Wednesday, and on Saturday picked in the top A.F.L., Rugby League or union competition.

This is still going on. "Oh yes! I have some blocks. Whack them in and see what happens." Total ignorance of, or disregard for, the basic rules. The tests to see whether it is an upper or lower motor neuron lesion. Is it structural or neurological? How many tests indicate Cat. I? How many indicate Cat. II? If you think it is a Cat. II what is it you should do on the first visit, leave for 3 days and test again to see if it really is a Cat. II, or if blocking is even necessary? How many know, and apply the rules you have been taught, and practice precisely, not sloppily? How many locate, and contact, the fossae **exactly**? And it has to be EXACTLY, or your analytical decision is usually wrong.

The S.O.T. basics are sound and can be used to enhance any technique. Scott and I used to tell the classes that we understood that some present would perhaps never use S.O.T. as a technique, but some of the tests and what they meant, would always stick in their mind and help in their understanding of that with which their patient was presenting. But taken out of context, and without supporting evidence, no test can indisputably stand alone, and that includes especially the Arm Fossae test.

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CATEGORY SIX – THE ANTERIOR VERTEBRAL SUBLUXATION cont'd...

produce a loss of lordosis or military lumbar spine. Some years after Ferguson someone actually read his paper and said, "Oh no! He did all his sacral base angle measurement non gravity-bearing." Stand the patients up and take a series of lateral lumbar views and the new average is 41° (range 38°- 42°). This is useful to us in the study of Category 6 as we can now use Ferguson's corrected angle value to determine our patients' course of care, of course, after we have stabilised their Cat. III, II or I condition.

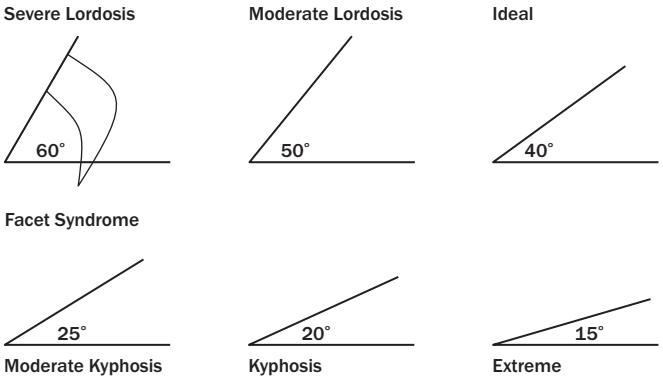
On the sacral base, DeJarnette[4] stated: "The position of the sacral base is important to health but is surely not the sole cause of musculoskeletal problems. It must be considered that the patient's build has much to do with his ability to live with an abnormal Ferguson's angle in comfort. Some of the world's strongest men have severe lumbosacral lordosis to a major degree. The lumbar lordosis is no more conducive to back problems than is the lumbar kyphosis."

The problem with the lordotic or kyphotic sacrolumbar spine is one of age, as many serious problems do originate here with advanced age and degenerative joint dysfunction.

A Study of Ferguson's Angle as Related to Spine Comfort

The basic information of value in the lateral sacrolumbar film is of course the ability to study the disc structures, the spinal ligaments and the facet system. Early detection of an oncoming Category III is much easier to handle than would be such a problem in full bloom.

In the modem practice of Chiropractic, the prone or sitting lumbar posterior to anterior thrust techniques have all but disappeared so DeJarnette's 1970 admonition doesn't apply to many. He wrote: "It would be well to never increase a sacrolumbar curve by adjusting down into it. Thus you would not thrust posterior to anterior into a 70 degree sacral base, but you would find it beneficial to thrust posterior to anterior onto a sacrolumbar spine with 20 degree angulations."



The point DeJarnette was trying to make in 1970 and in the "Category Six" classification — anterior lumbar part thereof was that **the ability to work is not as dependant upon the sacro-lumbar spine as it is upon the pelvis or the Occipito-Atlantal region**. Exercise and the use of the SB+ or SB- blocks are the thing to do, as we will outline at the end of this article. The rule of thumb is to remember to decrease the anterior and increase the posterior.

The Sacrovertebral Angle

We first came across this term in a text book called "Chiropractic Orthopedy" by Donald Pharaoh[5] who was a Palmer lecturer and an Australian; the book was written at Palmer in the late 50's. If you ever get a chance to pick up a copy of this you will want to read it from cover to cover. As well, if you are at a seminar and come across Dr. Rolf Peters, the editor of the Chiropractic Journal of Australia, discussion of his experience at Palmer in this era (the 50's when BJ was still lecturing) will fascinate you.

The Sacrovertebral angle is also called the Lumbosacral disc angle by some. It is formed by intersection of the line drawn through the inferior end plate of the fifth lumbar and the superior end plate of the first sacral segment, in other words, the line you've already drawn to measure Ferguson's angle.

Years ago when we were learning Spinography and reading Pharaoh the magic number for the sacrovertebral angle was twelve degrees. Lately, the 'normal range" is considered to be better form and in sacrovertebral angles case this range is ten to fifteen degrees.

You will see a twenty degree sacrovertebral angle and want to do something about it, just like you will want to jump in and do something for the Spondylolisthesis. Likewise, when you see a sacrovertebral angle of 4°, you will say to yourself "that couldn't be good." A prominent lordosis of the lumbar spine with an exceedingly serious dorsal kyphosis, yet the sacral base angle is fine but with a 4° sacrovertebral angle — the question you ask yourself is: "how do I extend the sacrolumbar spine and not alter the Ferguson's angle in so doing?'

Defining the Lordotic Lumbar Spine

It may come as a bit of surprise to many of our readers that the defining of an ideal lumbar spine is a relatively recent event. Don Harrison[6] who we referenced in the Anterior Thoracic article has done a fantastic job in describing the ovoid shaped lumbar spine, in terms of DeJarnette's Category Six, the anterior lumbar spine which appears in postural analysis can be a true lumbar lordosis whereby the lumbar curve is hyperlordotic with the curve positioned anteriorly to the second sacral segment **or** the very common "sway back" where the thoracolumbar spine is posteriorly translated.

Corrective Procedures

The situation we have with the Spondylolisthesis, the changed sacral base angle, the changed sacrovertebral angle, the increased lordosis or the posterior translated thoracolumbar spine is always secondary in importance to our categorisation of the patient as Category I, II or III.

So you have stabilised that Category III, Category II or Category I. You are in the healing phase and you are moving into structural reconstruction.

DeJarnette offered the blocking procedures and suggested some home exercises with an admonition as applicable today as it was in 1970, that being: "the difficulty here lies in the well known fact that as soon as the back problem lessens, the patient abandons the exercises."[7]

Here in turn are the supine lumbar lordosis exercise, the recovery exercises for lumbar anteriority and the spondylolisthesis techniques.

CATEGORY SIX – THE ANTERIOR VERTEBRAL SUBLUXATION cont'd...

The Lordotic Lumbar Spine Home Exercise

This is applied when Ferguson's angle exceeds 45°.

Step 1 is supine body extension. Have the patient lie down on a firm surface and stretch full length as if he wanted to gain height. Hold as a passive exercise for ten seconds, relax and repeat ten times.

Step 2 (Patient is in same supine position for all 3 steps) Begin with the right leg. Leg is flexed and grasped back of knee by patient's hands. This is a resistance exercise. Patient pulls leg as close to body as possible, while leg muscles resist this movement. Leg is then told to use its muscles to try and get back to table as patient holds against movement. Repeat five times. Then use left leg for tive times. Move leg slowly. Use full leg strength and full arm strength.

Step 3 DeJarnette's approach was to delay this exercise for several days to determine patient compliance. If the patient wasn't doing stretch, right leg, left leg steps as above then it was pointless giving step 3. However, if the patient followed through on the single leg exercises they would receive its benefits and step 3 was included. Simply, step 3 is bilateral leg movement. Pull legs up towards the body, with two hands resisting behind knees. Legs pull themselves away from the body, with patient's arms resisting. It isn't the amount of movement, but the amount of resistance that makes the corrections, It has to be used over a long period of time, as you are retraining muscle groups.

b) Recovery Exercises for Lumbar Anteriority

The goal is to retrain the total muscle structure of your patient's pelvis. While at work, your patient can take a few minutes and do the following twice per day. Patient stands with back to a wall – feet six inches from wall – lifts his pubes anteriorly and lowers the buttocks – holds for ten seconds. While pubes are lifted and buttocks lowered, he lifts one leg and then the other. Patient then steps away from the wall – stands on toes, elevates pubes.

c) Spondylolisthesis Techniques

DeJarnette suggested the important point was not to do anything that would further damage this area. The so-called "million dollar chiropractic roll" is definitely taboo. As we mentioned previously, techniques involving prone thrusting to the lumbar region are not much taught these days, but in 1970, this was also something DeJarnette was concerned about as he was with any technique with rigorous leg movements. (Leg pull or 'black snake whip' type methods, as they were called years ago.)

The DeJarnette blocks in SB plus position is the safest and best approach. This could also be the statement for the patient with an increased sacrovertebral angle or posteriorly translated thoracolumbar spine.

Home exercise consists of patient in the prone position over an exercise ball. The objective is to cause the lumbar lordosis to gravitate into flexion and pull the fifth lumbar posterior. This position should be maintained for fifteen minutes once per day if at all possible. Short periods are worse than none at all.

Anterior Cervical Spine

The Anterior cervical spine is most uncommon and when found it will be secondary to some increased thoracic condition like Scheuermanns disease. A more likely finding in the lateral x ray is a loss of lordosis with anterior translation and that, of necessity, requires a whole article on its own at some time in the future.

Conclusion

The fact that DeJarnette listed anterior vertebral subluxation as one of the further five category classifications reflects its importance. Dorsal anteriorities are most hazardous as they produce visceral dysfunction. Dorsal anteriorities are never malpositioned as a single unit but are in series, thus, DeJarnette's method of dorsal block or thenar placement was to find the lowest level, i.e. the base of the anterior section. In the lumbar region, an increased sacral base or changed sacrovertebral angle is something to be corrected following Category I, II, III procedures. Our own clinical experience is that the SB+ blocking position can be most helpful with a healing Category II/Spendylo patient. If in doubt, check with the arm fossae, which, of course is standard procedure.

Our next issue's topic will be the oblique sacrum. How does that short leg affect the Category II and when do you use a leveller? We hope to see some of you at this year's seminar series. It's always good to review the basics.

John S. Kyneur *Peter J. Kyneur*
Haberfield, Sydney NSW *Toronto, NSW*

References

1. *Fligg B. "Anterior Thoracic Subluxation" JCCA*
2. *Pettibon B.R. "Thoracic Spine" Lecture notes, 1978*
3. *Prill C. "Prill Analysis" privately published 1986*
4. *DeJarnette M.B. SOT Manual 1970" Nebraska*
5. *Pharaoh D. "Chiropractic Orthopedy" Palmer 1956*
6. *Harrison D.D CBP website*
7. *DeJarnette M.B. "SOT Manual 1970" Nebraska*

LETTER TO THE EDITOR cont'd...

EARLY INTEREST IN S.O.T.

While Scott had a much closer personal association with Dr de Jarnette, I had an experience with him that predated anyone else currently in Australia of whom I know. In August 1965 or '66, De Jarnette visited the Davenport Campus of Palmer College and gave a lecture on the Homecoming Programme. I was fortunate to be able to attend and I still have my notes of that class. I was very much impressed with his presentation, especially as I had already had cause to question some gaps in other techniques such as anatomical/functional short leg explanations, and subsequent treatments. One thing I distinctly remember was the Sitting Disc technique, and Dr de Jarnette advocating the use of a piano stool reversed, so the posterior of the buttocks was on the lower edge of the sloped bottom to facilitate the pumping of the vertebra to relieve the discal herniation.

His mere presence there was a landmark, as B J would not allow him near the College, but he had died a few years before, and Dr Dave Palmer had given him permission, because Dr de Jarnette was the only one who had been able to help Dr Dave with a health problem which he had.

A number of us in the clinic were unhappy with the results we were not getting with the standard technique package we were allowed to use and that was used on us – Toggle Recoil, Gonstead and Diversified. I had already gone to off-campus Thompson technique seminars with Dr Clay Thompson and Dr Willard Smith and seen 3cm so called anatomical deficiencies disappear with one atlas adjustment, and so questioned some of the dogmas of techniques. I also had met and been taught by Dr Gonstead, Dr Cox, Dr Stoenner (I interned with him for 3 months) and others who taught for Dr Gonstead. I went to his very impressive clinic at Mt Horeb twice, and was hosted in their Frank Lloyd Wright home by he and his wife.

A fellow student, Jean Pierre Choiniere from Quebec was similarly unhappy with the lack of results he had been receiving in the student clinic. From his chiropractor brother he had acquired a mysterious chart with lines, columns and numbers which was 'S.O.T.' We did not know what it meant, but in retrospect it was an occipital fibre, CMRT chart in its early form, when no line 1, 2 and 3 existed. So in our ignorance, if we found a nodule on T8 transverse, we adjusted that as well as L4 and C6 because they were listed in the same column. We know now that was wrong, but, we got results, and we each responded better to that than to any other technique. But if we had been discovered, we perhaps would not have passed clinic, even though we used it only on each other.

So, I was impressed with the tiny bit of S.O.T. to which I had been exposed, but had no opportunity to learn any more.

AUSTRALIAN DEVELOPMENTS

Returning to Australia, I joined my mentor David Goodrich in practice in Grafton and shortly after took it over when David moved to Parramatta. I had brought with me from the USA an hylo with a Thompson pelvic drop, a Nicholas side posture toggle recoil table, and a Thompson portable drop head piece. The late Allan Brady in Wodonga with whom I had played Rugby for Palmer, was as far as I knew then, the only other Thompson practitioner. Three months later I went to the A.C.A. Federal Conference in Adelaide where Drs Hildebrand and Strang from P.C.C. were the speakers (1968). This is where Dr Strang first released his now famous scientific irrefutable rationale for chiropractic that defuses all "medical" type attacks. While there Allan and I went to visit another D.C. who had been practising Thompson for years, and thus was probably the first and only Thompson practitioner in Australia until Allan came. Unfortunately his name eludes me.

In 1969 the Federal Conference was in Perth and the speaker was Dr Henri Gillet from Belgium. He was one of the small group in Europe especially in Switzerland and Belgium who were making ground breaking discoveries with x-ray techniques, and understanding of sacral motion and spinal hyper or hypo motion. Fascinating research, too little known and used today but utilised superficially by many without understanding its history or context. Dr Gillet's work was the forerunner of what became known as Motion Palpation technique. Joints, not just the spine were examined. The major fixation was determined. An adjustment or a strain or stress would be applied and huge changes would occur throughout the body. One startling and never to be forgotten lesson from this was the case of Dr Neville Creed of Mt Gambier, who later was one of the early S.O.T. group. Dr Creed had a sciatica of many years standing which had not responded to anyone's ministrations. Dr Gillet examined him, found a primary fixation in his wrist, adjusted it and the sciatica disappeared.

A salutary lesson for all, and a principle that we frequently see when S.O.T. is properly applied. FIND the CAUSE/SUBLUXATION. Adjust it, and leave everything else alone. (B.J. Palmer). Too much chiropractic effort and time is spent "chasing" and manipulating compensations and not dealing with the PRIMARY SUBLUXATION. This happens when the D.C. (Doctor of Causes), takes shortcuts, and becomes the doctor of Compensations and Symptoms.

Dr Keith Bastian

Ed: This is Part 1 of a comprehensive letter written by Keith capturing a first hand insight into the history of SOT in Australia. Stay tuned for the next installment. Thanks Keith for churning the cogs over and revisiting the infancy of SOT in Australia. As you said, to develop and go forward in the future we need to look from where we have come .....

CLASSIFIEDS

LOCUMS REQUIRED

Locum required for September at fabulous Forster in spring. Enjoy the best coastal and lake area in Australia, including dolphins and whales, sailing, water sports, white water canoeing, house boating and many other activities. Low stress and plenty of time for fun, working only 12 hours/wk at the moment. Contact: **kairos3@bigpond.com** or phone Keith **A/Hrs: (02) 6554 7425**

Locum Position. Mill Street Chiropractic Centre, Ballarat, requires a motivated Chiropractor to fill in for existing associate on maternity leave from August until December 2008. One or two days a week with hours to suit. Working with two other chiropractors in an attractive and stable practice with an experienced and supportive C.A. team. Our philosophy is wellness-based family maintenance care and we have a low-stress practice with great patients! Low force techniques, primarily S.O.T. For further details please contact: **larraine@ballarat.hotkey.net.au**

Long term locum required for 2 full days, 2 half days in beautiful Noosa Sunshine Coast QLD. Position available as of June. Practice SOT based with some manual techniques. Must have genuine passion for the wellbeing of clients and be willing to grow existing client base in a harmonious supportive environment. Email: **schiro@bigpond.net.au** or **0438 716 402**

Locum Required. Well versed, confident and energetic person required for busy practice. For 2 half days and 2 full days on the gorgeous Sunshine Coast. From beginning of July for 5-6 week period. Practice SOT based with some manual techniques. Email: **mmoeliker@bigpond.com**

ASSOCIATES REQUIRED

Expressions of interest are invited for one of the premier, and oldest S.O.T. practices. Injuries are making it increasingly difficult for Keith to continue working, and he would like an enthusiastic and compassionate SOTer to take over. Modern spacious clinic, capable staff and loyal patients, some in their 4th generation of care with KB. Contact Keith on **(02) 6554 7425 A/Hrs**, or **kairos3@bigpond.com**

Associate Needed. Energetic young associate looking to join our Sunshine Coast Practice. Long established practice with existing patient base. We are looking for someone who would be able to start within 2-3 weeks. Please contact us at **mmoeliker@bigpond.com** if you are interested.

Associate Wanted. Busy Ashgrove practice looking for a part time associate 4 - 5 shifts per week. Remuneration at 50% plus GST. Would suit a family oriented person. Shifts and hours are flexible. Primary techniques include SOT, Activator and Diversified. Please contact Paulette Walker **(07) 3366 6373** or **0438 660 081**

LOCUMS AVAILABLE

SOT Locum Available. Mindy Hayes, (NZCC) available for locum. Ballina based. Wellness Philosophy. Available dates: 24th March 08 to 4th April 08, then 5th April to 4th July 08, then from 17th October 08. Contact: **mindylouhayes@gmail.com** or **0423 11 33 61**

Experienced S.O.T. Locum available. Scott Palmer is available to look after your practice for school holidays and beyond. 10 years experience. Phone: **0405 445 722** Email: **spinalscotty@yahoo.com**

Dedicated and Proficient SOT Locum. Categories, CMRT, Cranial, Extremity, Paediatrics (Basic Certification Attained). Available April 14th to June 1st 2008 & July 21st 2008 onwards. Based in Melbourne. Available for long term (Melb Metro) & short term (VIC, QLD, SA) locums. Associate & locum experienced in many SOT practices. Also skilled in STO, Activator, Diversified, Drop, Upper Cervical, other low force techniques & clinical nutrition. Contact Dr Jonathan Lubetzky **0401 038 871** or **jlubetzky@gmail.com**

PRACTICES FOR SALE

Brisbane Clinic For Sale. Located 5km from CBD in one of Brisbane's most sought after suburbs. Loyal patient base. Income $120k gross last year. Established 5 years with new fixtures. Tasteful fitout. Chiro works part time but ample room to grow. Room rented to other therapists to assist with rent. Chiropractor locating interstate. Priced to sell. Serious enquiry only. **yournewclinic@optusnet.com.au** or **0416 115 189** after 6pm.

Looking for a lifestyle change? Well established (16 years) thriving practice for sale in the heart of Noosa, Sunshine Coast QLD. SOT based with diversified and activator. Suit chiropractor with a genuine integrity and care for clients. Gross 280K average 120-130 clients/week. Fantastic support staff... still potential for growth. Principal changing to alternative healing modality. Committed to smooth transition. Inquiries: email **schiro@bigpond.net.au** or **0438 716 402**

Chiropractic office and property for sale. Separate or together. Located in the centre of broader Sydney. Northmead is in between Parramatta and the Hills district. Subluxation based SOT practice est. for 20 years with 50% of members on a lifetime fortnightly adjusting program. Grossed $170K last year operating 2 full and 2 half days. Huge opportunity for expansion. Property is a large 1088sqm with the prospect of further development. Would consider sale of property or business, or discount for the purchase of both. Call Shaun – **(02) 9639 6307**

ANNUAL CONVENTION & SOTOA AGM

Cairns International Hotel, Cairns, Far North Queensland

November 1 & 2, 2008

Advanced Module Feedback from SOTOA Members

In order to provide what you, our members want, we would like your feedback as to what Advanced Module you would like to see offered on July 19, 2008 in Sydney as part of our aim to offer more to our members and the S.O.T. community.

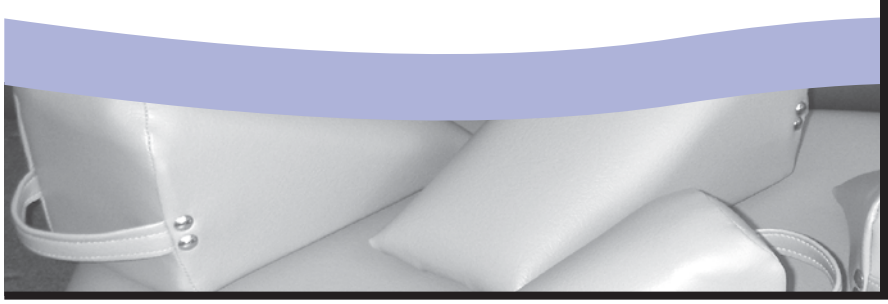
Simply complete the questionnaire below and return to Averil as soon as you can.

		Yes	No
	Are you interested in attending an Advanced SOT Module in 2008		
	SOT Advanced Modules that could be offered in July 2008		
1	**Extremities** This module covers the systematic approach to extremity adjusting including the SOT indicators and rationale for adjustment. Practical adjusting skills are covered in details such that you will be able to put them into practice immediately.		
2	**Sutural Technique** This module describes DeJarnette's Sutural Technique which is used to facilitate Category II adjustments when sutural stress has prevented a Category II adjustment from holding. It also equips practitioners with a means of finishing TMJ adjustments where results are incomplete.		
3	**Category One Intra-oral Adjustments** This module covers the cranial analysis and adjustments for specific occipital, frontal and temporal bone lesions. These adjustments are done with an assistant, and all assistants holds are covered.		
4	**Cranial Specific and Non-Specific Techniques** This module covers the specialized techniques in SOT, some of which are extremely useful on a day to day basis. Includes techniques that can be applied for specific conditions, etc. – headaches, asthma and blood pressure disturbances to name a few.		
5	**SOT Paediatrics** This module covers the SOT approach to the management of pregnancy and babies as well as children. It includes a protocol for thorough paediatric assessment and treatment of many commonly occurring paediatric conditions including: otitis media, enuresis, such disorders and infantile colic.		
6	**CMRT Continuation** This module revises the principle and indicators for CMRT and covers the techniques not presented in the Basic SOT Seminar Series.		

*1 being the **MOST** likely to attend*
*and 5 being **LEAST** likely to attend.*

	Rate SOT Advanced Modules on a Scale of 1 to 5	1	2	3	4	5
1	**Extremities**					
2	**Sutural Technique**					
3	**Category One Intra-oral Adjustments**					
4	**Cranial Specific and Non-Specific Techniques**					
5	**SOT Paediatrics**					
6	**CMRT Continuation**					

Fax this page to SOTO Australasia (07) 5442 3322



SOTO AUSTRALASIA

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